CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Form Approved
OMB NO. 0920-0009

Demographic Data:

Patient's name: _____
Last First
State of residence: _____ **County:** _____

Sex: ☐Male ☐Female **Age:**_____ **Date of birth (mm/dd/yy):**____/____/____

Race/Ethnicity (select one or more)**:**
☐☐American Indian or Alaska Native ☐☐Black or African American ☐☐Native Hawaiian or Other Pacific Islander
☐☐Asian ☐☐Hispanic or Latino ☐☐White
☐☐Unknown

Physician's Name:_____ **Phone:**__ __ __-__ __ __-__ __ __ __
Physician's Email: _____

Clinical Data: (NOTE: for dates, be as specific as possible. However, approximations (e.g., mm/yy) are okay.)

Date of illness onset (mm/dd/yy): ___/___/____ ☐Unknown

Signs and symptoms:
Diarrhea: ☐Yes ☐No ☐Unknown
Maximum number stools per day:_____ (unknown = 999)
Weight loss: ☐Yes ☐No ☐Unknown
Baseline weight: __ __ __ lbs. (unknown = 999)
Number of pounds lost: _____
Fever: ☐Yes ☐No ☐Unknown
Temperature (if measured):_____degrees F (unknown = 999)
Hospitalized (at least overnight): ☐Yes ☐No ☐Unknown
If yes, list name of hospital: _____ Date of admission: ___/___/___

Fatigue: ☐Yes ☐No ☐Unknown
Anorexia: ☐Yes ☐No ☐Unknown
Nausea: ☐Yes ☐No ☐Unknown
Vomiting: ☐Yes ☐No ☐Unknown
Abdominal cramps: ☐Yes ☐No ☐Unknown
Other symptoms (specify): _____
_____

Stool collection date: ___/___/___ **Results:** ☐Positive ☐Negative ☐Unknown

Confirmed by state lab? ☐Yes ☐No ☐Unknown **Confirmed by CDC lab?** ☐Yes ☐No ☐Unknown

Was the case-patient treated for cyclosporiasis? ☐Yes ☐No ☐Unknown
If yes, what medication was provided? ☐☐trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)
☐☐Other (specify): _____ ☐Unknown
Is case-patient sulfa-allergic? ☐Yes ☐No ☐Unknown

Epidemiologic Data: (NOTE: for dates, be as specific as possible. However, approximations (e.g., mm/yy) are okay.)

History of Travel (during the 2 weeks before onset of illness): □ Yes □ No □ Unknown

International travel (country): □ Unknown dates (**check here if dates are unknown**)

(1)_____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(2)_____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(3)_____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

Travel in the United States (state): □ Unknown dates (**check here if dates are unknown**)

(1)_____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(2)_____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(3)_____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

Exposures (during the 2 weeks before onset of illness):

Ate fresh berries: □Yes (if yes, specify types below; check all that apply) □No □Unknown

□Strawberries □Blackberries □Blueberries

□Raspberries □Black raspberries □Golden raspberries □Unknown type of berry

□Other type of berry (specify):_____

Ate fresh herbs: □Yes (if yes, specify types below; check all that apply) □No □Unknown

□Cilantro □Oregano □Thyme □Mint □Dill □Parsley □Rosemary

□Basil (specify types): □Sweet basil □Thai basil (i.e., green leaves and purple stems)

□Purple basil (i.e., purple leaves and stems)

□Other type of herb (specify): _____

□□□□Unknown type of herb

Ate lettuce: □Yes (if yes, specify types below; check all that apply) □No □Unknown

□Mesclun (a.k.a., spring mix, field greens, baby greens, & gourmet salad mix)

□□□□Arugula

□Other type of lettuce (specify): _____

□Unknown type of lettuce

Ate other types of fresh produce: □Yes (if yes, specify types below; check all that apply) □No □Unknown

□Fruit, other than berries (specify types): _____

□Unknown type of fruit

□Other type(s) of fresh produce (specify): _____

_____

□Unknown type of fresh produce

Did the case-patient attend any events (e.g., wedding reception) during the 2 weeks before symptom onset? □ Yes □ No □ Unknown

If yes, specify type of event: _____

Event date: ___/___/___

Does the case-patient know of any other ill persons? □ Yes □ No □ Unknown

If yes, did health department collect contact information about other ill persons and investigate further (provide comments below)?

□ Yes □ No □ Unknown

Comments and additional data:

Name (person filling out form):_____
Title:_____
Phone: __ __ __-__ __ __-__ __ __ __ **FAX:** __ __ __-__ __ __-__ __ __ __
Email: _____
Name of investigating health department: _____
Date form completed: ___/___/___

Revised 9/3/02