CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Demographic Data:	
Patient's name:	
Patient's name:Last State of residence:	First County:
Sex: IMale IFemale Age:	Date of birth (mm/dd/yy)://
Race/Ethnicity (select one or more):IIIAmerican Indian or Alaska NativeIIIBlack or African AmericanIIIAsianIIIHispanic or LatinoIIIVIIIUnknownIIIAsianIIIHispanic or Latino	IIINative Hawaiian or Other Pacific Islander White
Physician's Name: Physician's Email:	Phone:
Clinical Data: (NOTE: for dates, be as specific as possible. How	ever, approximations (e.g., mm/yy) are okay.)
Date of illness onset (mm/dd/yy):// Unknown	
Maximum number stools per day: (unknown = 999) Weight loss:	Nausea: IYes INo IUnknown miting: IYes INo IUnknown Abdominal cramps: IYes INo IUnknown her symptoms (specify):
Stool collection date:// Re	sults: Positive Negative Unknown
Confirmed by state lab? IYes INo IUnknown Co	onfirmed by CDC lab? IYes INo IUnknown
Was the case-patient treated for cyclosporiasis? IYes INo If yes, what medication was provided? IIItrimethoprim/sulfamethoxa IIIOther (specify): Is case-patient sulfa-allergic? IYes INo IUnknown	azole (e.g., Bactrim, Septra, Cotrim)

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

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

History of Travel (during the 2 weeks				s 🛛 🗠 No	Unknown
International travel (country):	Unknown d	ates (check h e	ere if dates a	re unknown)	
(1)	Departure c	date (mm/dd/yy)	/	Return date (m	1m/dd/yy)// nm/dd/yy)//
(1) (2)	Departure (date (mm/dd/yy)		Return date (n	nm/dd/yy)//
(3)	Departure (date (mm/dd/yy)		Return date (n	nm/dd/yy)//
Travel in the United States (state):	🛛 🛛 Unknown d	dates (check he	re if dates are	unknown)	
(1)	Departure (date (mm/dd/yy)	1 1	Return date (n	nm/dd/yy)//
(2)	Departure (date (mm/dd/yy) date (mm/dd/yy)		Return date (n	nm/dd/yy) / /
(3)	Departure (date (mm/dd/yy)		Return date (n	nm/dd/yy)// nm/dd/yy)//
		()))		,	
Exposures (during the 2 weeks befo	re onset of il	Iness).			
Ate fresh berries: "Yes (if yes			all that apply	0 ONO	Unknown
IStrawberries IBlackber	ries		es		
Raspberries Black ras	snherries	IGolden r	asnherries	01 Inki	nown type of herry
Other type of herry (specify):	spoemes		uspbernes	UOTIKI	lowin type of being
Other type of berry (specify):					
Ate fresh herbs: 1 Yes (if yes, state)	cnooify typoc	holow: chook a	ll that apply)	INO	Unknown
Cilantro Oregano					、 、
Basil (specify types): Swe				and purple stei	ms)
		, purple leaves			
Other type of herb (specify):				
0000Unknown type of herb					
Ate lettuce: DYes (if yes, spec DMesclun (a.k.a., spring mix DDDArugula Other type of lettuce (speci DUnknown type of lettuce	, field greens,	baby greens,	& gourmet sa	lad mix)	Jnknown
Ato other types of freeh produc				al all that analy	
Ate other types of fresh produc		es, specily type	es below; che	ck all that apply	y) lino lunknown
IFruit, other than berries (sp	ecity types):				
Unknown type of fruit					
Other type(s) of fresh prod	uce (specify):	• • • • • • • • • • • • • •			
Unknown type of fresh prod	duce				
Did the case-patient attend a	ny events (e.	.g., wedding r	eception) du	ring the 2 wee	ks before symptom
onset? I Yes I N		3, 3	, , , , , , , , , , , , , , , , , , , ,	J	
If yes, specify type of event:					
Event date: / /	•				
Does the case-patient know	of any other	ill porcono?		No 🛛 U	nknown
If yes, did health department co	Silect contact	mormation ab	out other ill pe	ersons and inve	esugate iurther (provide
comments below)?					
🛛 Yes 🛛 No 🖓 Un	known				

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