



# Respiratory Disease Cluster Case Investigation Form

Form Approved  
OMB No. 0920-1011  
Exp. Date 03/31/2017

State: \_\_\_\_\_ Date reported to health department: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY) Date interview completed: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

State Epi ID: \_\_\_\_\_ State Lab ID: \_\_\_\_\_

Household ID (CDC use only): \_\_\_\_\_ CDC ID (CDC use only): \_\_\_\_\_ Cluster ID (CDC use only): \_\_\_\_\_

1. At the time of this report, is the case  
 Confirmed     Probable     Case under investigation (skip to Q.3)     Not a case (skip to Q.3)
2. What is the subtype?  
 Influenza A(H1N1) **variant**     Influenza A(H1N2) **variant**     Influenza A(H3N2) **variant**     Influenza A(H5N1)  
 Influenza A(H7N9)     Other \_\_\_\_\_     Unknown

### Demographic Information

3. Date of birth: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)
4. Country of usual residence: \_\_\_\_\_ If usual resident of U.S., county of residence: \_\_\_\_\_
5. Race:  White     Asian     American Indian/Alaska Native     Black     Native Hawaiian/Other Pacific Islander  
(check all that apply)
6. Ethnicity:     Hispanic or Latino     Not Hispanic or Latino
7. Sex:     Male     Female

### Symptoms, Clinical Course, Treatment, Testing, and Outcome

8. What date did symptoms associated with this illness start? \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

9. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If fever present, date of onset ___/___/___ (MM/DD/YYYY)		Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Felt feverish	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If felt feverish, date of onset ___/___/___ (MM/DD/YYYY)		Eye infection/redness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

10. Does the patient still have symptoms?  
 Yes (skip to Q.12)     No     Unknown (skip to Q.12)
11. When did the patient feel back to normal? \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)
12. Did the patient receive any medical care for the illness?  
 Yes     No (skip to Q.29)     Unknown (skip to Q.29)
13. Where and on what date did the patient seek care (check all that apply)?  
 Doctor's office **date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)     Emergency room **date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)  
 Urgent care clinic **date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)     Health department **date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)  
 Other \_\_\_\_\_ **date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)     Unknown
14. Was the patient hospitalized for the illness?  
 Yes     No (skip to Q.23)     Unknown (skip to Q.23)
15. Date(s) of hospital admission? **First admission date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY) **Second admission date:** \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)
16. Was the patient admitted to an intensive care unit (ICU)?

Public reporting burden of this collection of information is estimated to average 30 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



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- Yes     No (skip to Q.18)     Unknown (skip to Q.18)
17. Date of **ICU admission**: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) Date of **ICU discharge**: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)
18. Did the patient receive mechanical ventilation / have a breathing tube?  
 Yes     No (skip to Q.20)     Unknown (skip to Q.20)
19. For how many days did the patient receive mechanical ventilation or have a breathing tube? \_\_\_\_\_ days
20. Was the patient discharged?  
 Yes     No (skip to Q.23)     Unknown (skip to Q.23)
21. Date(s) of hospital discharge? **First discharge date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY) **Second discharge date**: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)
22. Where was the patient discharged?  
 Home     Nursing facility/rehab     Hospice     Other \_\_\_\_\_     Unknown
23. Did the patient have a new abnormality on chest x-ray or CAT scan?  
 No, x-ray or scan was normal     Yes, x-ray or scan detected new abnormality     No, chest x-ray or CAT scan not performed     Unknown
24. Did the patient receive a diagnosis of pneumonia?  
 Yes     No     Unknown
25. Did the patient receive a diagnosis of ARDS?  
 Yes     No     Unknown
26. Did the patient have leukopenia (white blood cell count <5000 leukocytes/mm<sup>3</sup>) associated with this illness?  
 Normal     Abnormal     Test not performed     Unknown
27. Did the patient have lymphopenia (total lymphocytes <800/mm<sup>3</sup> or lymphocytes <15% of WBC) associated with this illness?  
 Normal     Abnormal     Test not performed     Unknown
28. Did the patient have thrombocytopenia (total platelets <150,000/mm<sup>3</sup>) associated with this illness?  
 Normal     Abnormal     Test not performed     Unknown
29. Did the patient experience any other complications as a result of this illness?  Yes (please describe below)     No     Unknown

30. Did the patient receive influenza antiviral medications prior to becoming ill (within 2 weeks) or after becoming ill?  
 Yes, (please complete table below)     No     Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Other influenza antiviral _____				mg

31. Did the patient die as a result of this illness?  
 Yes, **Date of death**: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)     No     Unknown

### Influenza Testing

32. When was the specimen collected that indicated novel influenza A virus infection by Reverse Transcription-Polymerase Chain Reaction (RT-PCR)? \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)
33. Where was the specimen collected?  Doctor's office     Hospital     Emergency room     Urgent care clinic     Health department     Other \_\_\_\_\_     Unknown
34. Was a rapid influenza diagnostic test (RIDT) used on any respiratory specimens collected?  
 Yes     No (skip to Q.38)     Unknown (skip to Q.38)
35. When was the RIDT specimen collected? \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)
36. What was the result?  Influenza A     Influenza B     Influenza A/B (type not distinguished)     Negative     Other \_\_\_\_\_
37. What brand of RIDT was used? \_\_\_\_\_

### Medical History -- Past Medical History and Vaccination Status

38. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.
- a. Asthma/reactive airway disease     Yes     No     Unknown
- b. Other chronic lung disease     Yes     No     Unknown (If YES, specify) \_\_\_\_\_
- c. Chronic heart or circulatory disease     Yes     No     Unknown (If YES, specify) \_\_\_\_\_



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- d. Diabetes mellitus  Yes  No  Unknown (If YES, specify) \_\_\_\_\_
  - e. Kidney or renal disease  Yes  No  Unknown (If YES, specify) \_\_\_\_\_
  - f. Non-cancer immunosuppressive condition  Yes  No  Unknown (If YES, specify) \_\_\_\_\_
  - g. Cancer chemotherapy in past 12 months  Yes  No  Unknown (If YES, specify) \_\_\_\_\_
  - h. Neurologic/neurodevelopmental disorder  Yes  No  Unknown (If YES, specify) \_\_\_\_\_
  - i. Other chronic diseases  Yes  No  Unknown (If YES, specify) \_\_\_\_\_
39. Does the patient frequently use a stroller or wheelchair? If yes, please describe.  
 Yes \_\_\_\_\_  No  Unknown
40. Was patient pregnant or ≤6 weeks postpartum at illness onset?  
 Yes, pregnant (weeks pregnant at onset) \_\_\_\_\_  Yes, postpartum (delivery date) \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)  No  Unknown
41. Does the patient currently smoke?  
 Yes  No  Unknown
42. Was the patient vaccinated against influenza in the past year?  
 Yes  No (skip to Q.45)  Unknown (skip to Q.45)
43. Month and year of influenza vaccination? **Vaccination date 1:** \_\_\_/\_\_\_ (MM/YYYY) **Vaccination date 2:** \_\_\_/\_\_\_ (MM/YYYY)
44. Type of influenza vaccine (check all that apply):  Inactivated (injection)  Live attenuated (nasal spray)  Unknown

### Epidemiologic Risk Factors

45. In the 7 days prior to illness onset, did the patient travel outside of his/her usual area?  Yes  No (skip to Q.48)  Unknown (skip to Q.48)
46. When and where did the patient travel? **Please describe details of the patient's travel in the notes section at the end of the form.**  
**Trip 1:** Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ Country \_\_\_\_\_ State \_\_\_\_\_ City/County \_\_\_\_\_  
**Trip 2:** Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ Country \_\_\_\_\_ State \_\_\_\_\_ City/County \_\_\_\_\_
47. Did the patient travel in a group (check all that apply)?  
 No, travelled alone  Yes, with household members  Yes, with non-household members  Unknown

### Risk Factors—Domestic and Agricultural Animals

48. In the 7 days before becoming ill, did the patient attend an agricultural fair/event or live animal market?  
 Yes (specify name, if >1 fair, please describe in the notes section \_\_\_\_\_)  No (skip to Q.50)  Unknown (skip to Q.50)
49. In the 7 days before becoming ill, on what days did the patient attend an agricultural fair/event or live animal market (check all that apply)?  
 on the day of illness onset  1 day before illness onset  2 days before illness onset  3 days before illness onset  
 4 days before illness onset  5 days before illness onset  6 days before illness onset  7 days before illness onset
50. In the 7 days before becoming ill, did the patient have **DIRECT** contact with (touch or handle) any livestock animals like poultry or pigs?  
 Yes  No (skip to Q.53)  Unknown (skip to Q.53)
51. What type(s) of animals did the patient have direct contact with (check all that apply)?  
 Horses  Cows  Poultry/wild birds  Sheep  Goats  Pigs/hogs  Other \_\_\_\_\_
52. Where did the direct contact occur (check all that apply)?  
 Home  Work  Agricultural fair or event  Live animal market  Petting zoo  Other \_\_\_\_\_
53. In the 7 days before becoming ill, did the patient have **INDIRECT** contact with (walk through an area containing or come within 6 feet of) any livestock animals?  
 Yes  No (skip to Q.56)  Unknown (skip to Q.56)
54. What type(s) of animals did the patient have indirect contact with (check all that apply)?  
 Horses  Cows  Poultry/wild birds  Sheep  Goats  Pigs/hogs  Other \_\_\_\_\_
55. Where did the indirect contact occur (check all that apply)?  
 Home  Work  Agricultural fair or event  Live animal market  Petting zoo  Other \_\_\_\_\_
56. In the 7 days before becoming ill, did the patient have direct or indirect contact with any animal exhibiting signs of illness?  
 Yes (specify animal type and location \_\_\_\_\_)  No  Unknown

*Please answer Q.57–58 if ANY contact (direct, indirect, or both) with pigs/hogs identified above. If no contact identified, please skip to Q.59.*

57. In the 7 days before becoming ill, on what days did the patient have **ANY** contact (direct, indirect, or both) with pigs (check all that apply)?



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- on the day of illness onset   
  1 day before illness onset   
  2 days before illness onset   
  3 days before illness onset  
 4 days before illness onset   
  5 days before illness onset   
  6 days before illness onset   
  7 days before illness onset

58. From Q. 57, what was the total number of different days the patient reported **ANY** pig contact (direct, indirect, or both)? \_\_\_\_\_ days

59. Does anyone else in the household own, keep or care for livestock animals?

- Yes   
  No (skip to Q.61)   
  Unknown (skip to Q.61)

60. What type(s) of animals are kept or cared for by household members (check all that apply)?

- Horses   
  Cows   
  Poultry/wild birds   
  Sheep   
  Goats   
  Pigs/hogs   
  Other \_\_\_\_\_

### Risk Factors—Household, Occupational, Nosocomial, and Secondary Spread

61. Does the patient reside in an institutional or group setting (e.g. nursing home, boarding school, college dormitory)?

- Yes (skip to Q.63)   
  No   
  Unknown (skip to Q.63)

62. How many people resided in the patient's household(s) in the week before or after illness onset (excluding the patient)? \_\_\_\_\_

**A household member is anyone with at least one overnight stay +/- 7 days from patient's illness onset, and the patient may have resided in >1 household. Please complete the table below for each household member and continue in the notes section if more space is needed.**

ID	Household (HH)	Relation to patient (e.g. parent, brother, friend)	Sex (M/F)	Age	Fever or any respiratory symptom +/- 7 days from case patient's onset?	Date of illness onset	If HH member <b>ILL</b>		If HH member <b>NOT ILL</b>
							Any pig/hog contact ≤7 days before his/her onset?	Attend agricultural fair ≤7 days before his/her onset?	Pig/hog contact or fair attendance ≤10 days before patient's onset?
1	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

63. In the 7 days before or after becoming ill, did the patient attend or work at a child care facility?

- Yes (before becoming ill)   
  Yes (after becoming ill)   
  No (skip to Q.65)   
  Unknown (skip to Q.65)

64. Approximately how many children are in the patient's class or room at the child care facility? \_\_\_\_\_

65. In the 7 days before or after becoming ill, did the patient attend or work at a school?

- Yes (before becoming ill)   
  Yes (after becoming ill)   
  No (skip to Q.67)   
  Unknown (skip to Q.67)

66. Approximately how many students are in the patient's class at the school? \_\_\_\_\_ children

67. In the 7 days before or after the patient became ill, did anyone else in the patient's household(s) work at or attend a child care facility or school?

- Yes   
  No (skip to Q.69)   
  Unknown (skip to Q.69)

68. List ID numbers from Q.62 (the table above) for household members working at or attending a child care facility or school: \_\_\_\_\_

69. Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

- Yes   
  No   
  Unknown

70. In the 7 days before or after becoming ill, did the patient work in or volunteer at a healthcare facility or setting?

- Yes   
  No (skip to Q.73)   
  Unknown (skip to Q.73)

71. Specify healthcare facility job/role:

- Physician   
  Nurse   
  Administration staff   
  Housekeeping   
  Patient transport   
  Volunteer   
  Other \_\_\_\_\_

72. Did the patient have direct patient contact while working or volunteering at a healthcare facility?

- Yes   
  No   
  Unknown

73. In the 7 days before becoming ill, was the patient in a hospital for any reason (i.e., visiting, working, or for treatment)?



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Yes     No     Unknown

If yes, what were the dates? \_\_\_/\_\_\_/\_\_\_, \_\_\_/\_\_\_/\_\_\_    City/Town \_\_\_\_\_

74. In the 7 days before becoming ill, was the patient in a clinic or a doctor's office for any reason?

Yes     No     Unknown

If yes, what were the dates? \_\_\_/\_\_\_/\_\_\_, \_\_\_/\_\_\_/\_\_\_    City/Town \_\_\_\_\_

75. In the 7 days before becoming ill, did the patient have close contact (e.g. caring for, speaking with, or touching) with anyone **other than a household member** who routinely has contact with pigs/hogs?

Yes     No     Unknown

76. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient's illness onset?

Yes (**please list those ill before the case patient in the table below**)     No     Unknown

Relationship to patient	Sex (M/F)	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset?	Comments
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	

77. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **beginning AFTER** the case patient's illness onset?

Yes (**please list those ill after the case patient in the table below**)     No     Unknown

Relationship to patient	Sex (M/F)	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset?	Comments
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	

78. Is the patient a contact of a confirmed or probable case of novel influenza A infection?

Yes (**please list patient's confirmed or probable contacts in the table below**)     No     Unknown

Relationship to patient	State Epi ID	State Lab ID	Case status	Sex (M/F)	Age	Date of illness onset (MM/DD/YYYY)
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			

79. Any additional comments or notes (e.g. travel details, names/dates of fairs attended by case patient, dates of household members fair attendance and location of fair, information about other ill contacts)?

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