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Study ID: _____

**CEIRS Human Influenza Surveillance Study
Form 6A: Medical History**

The following questions are about the subject's recent medical care and medications.

1. ED arrival

Arrival Date: ___ / ___ / _____ (mm/dd/yyyy)

Arrival Time: ___ : ___ (hh:mm) (24-hour clock)

2. Has the subject been admitted to the hospital (i.e. stayed overnight) within the past 30 days?

No Yes Unknown

If Yes,

a. For how many days was the subject admitted? _____ Days

b. When was the subject discharged? ___ / ___ / _____ (mm/dd/yyyy)

3. Has the subject taken any antibiotics within the past 30 days?

No Yes Unknown

a. If Yes, how many antibiotics were taken? _____ Antibiotics

For each antibiotic received, specify the antibiotic name, date started, days taken, and condition it was prescribed for (i.e. indication; If unknown, please write "unknown").

Antibiotic 1

Name: _____

Date started: ___ / ___ / _____ (mm/dd/yyyy)

Days taken for: _____ Days

Indication: _____

Antibiotic 3

Name: _____

Date started: ___ / ___ / _____ (mm/dd/yyyy)

Days taken for: _____ Days

Indication: _____

Antibiotic 2

Name: _____

Date started: ___ / ___ / _____ (mm/dd/yyyy)

Days taken for: _____ Days

Indication: _____

Antibiotic 4

Name: _____

Date started: ___ / ___ / _____ (mm/dd/yyyy)

Days taken for: _____ Days

Indication: _____

4. Has the subject taken any influenza antivirals within the past 30 days?

- No Yes Unknown

Examples are: Oseltamivir (Tamiflu), Zanamivir (Relenza), Amantadine (Symmetrel), or Rimantadine (Fludine)

If Yes,

- a. Name of influenza antiviral _____
- b. Date the subject started the antiviral: ____/____/____ (mm/dd/yyyy)
- c. How many days did the subject take the antiviral for? _____ Days

5. Is the subject currently taking steroids (pill or injections)?

- No Yes Unknown

If Yes, how many steroids is the subject taking? _____ Steroids

For each steroid, specify the steroid name and dose.

Steroid 1

Name: _____
Dose: _____

Steroid 2

Name: _____
Dose: _____

Steroid 3

Name: _____
Dose: _____

Steroid 4

Name: _____
Dose: _____

6. Is the subject taking any medications that suppress their immune system?

- No Yes Unknown

If Yes, which medications (Check all that apply*)

- _____ Methotrexate
- _____ Tacrolimus (Propgraf)
- _____ Mycophenolate (Cellcept)
- _____ Other, specify: _____

* Please see Appendix 4 for a list of additional immunosuppressive medications

Medical History**The next few questions are about the subject's overall medical history.**7. Does the subject have Chronic Lung Disease? No Yes Unknown

If Yes, does the subject have:

Asthma? No Yes UnknownCOPD? No Yes UnknownCystic Fibrosis? No Yes Unknown

Other, specify: _____

8. Does the subject have any Cardiovascular Disease?

 No Yes Unknown

If Yes, does the subject have:

Coronary Artery Disease? No Yes UnknownCongestive Heart Failure? No Yes UnknownCardiomyopathy? No Yes UnknownVascular Disease? No Yes UnknownCongenital Heart Disease? No Yes Unknown

Other, specify: _____

9. Does the subject have Renal Disease? No Yes Unknown

If Yes, does the subject have:

End Stage Renal Disease? No Yes Unknown

Other, specify: _____

10. Does the subject have any Hepatic Disease? No Yes Unknown

If Yes, does the subject have:

Cirrhosis? No Yes UnknownHepatitis B? No Yes UnknownHepatitis C? No Yes Unknown

Other, specify: _____

11. Does the subject have any Endocrine/ Metabolic Disorders?

 No Yes Unknown

If Yes, does the subject have:

Diabetes? No Yes UnknownThyroid Disorder? No Yes Unknown

Other, specify: _____

12. Does the subject have any Hematological Disease?

No Yes Unknown

If Yes, does the subject have:

Sickle Cell Disease? No Yes Unknown

Lymphoma? No Yes Unknown

Leukemia? No Yes Unknown

Other, specify: _____

13. Does the subject have any Neurological Disorders?

No Yes Unknown

If Yes, does the subject have:

Stoke? No Yes Unknown

Seizure/Epilepsy? No Yes Unknown

Intellectual Disability? No Yes Unknown

Multiple Sclerosis? No Yes Unknown

Muscular Dystrophy? No Yes Unknown

Spinal Cord Disease or Injury? No Yes Unknown

Peripheral Nerve Disease? No Yes Unknown

Cerebral Palsy? No Yes Unknown

Other, specify: _____

14. Does the subject have HIV/AIDS?

No Yes Unknown

If Yes, does the subject have a recent (within the last 12 months) CD4 count?

No Yes Unknown

If Yes, what is their most recent:

CD4 count? _____

Date of CD4 count: ___ / ___ / ___ (mm/dd/yyyy)

15. Does the subject have an autoimmune disorder? No Yes Unknown

If Yes, specify autoimmune disorder: _____

16. Does the subject have/has the subject had Cancer?

No Yes Unknown

If Yes, specify Cancer: _____

Is the subject on Chemotherapy? No Yes Unknown

How many medications is the subject taking? (List up to 5)

Specify medications received and date of last dose:

Medication 1: _____ Date: ___ / ___ / _____

Medication 2: _____ Date: ___ / ___ / _____

Medication 3: _____ Date: ___ / ___ / _____

Medication 4: _____ Date: ___ / ___ / _____

Medication 5: _____ Date: ___ / ___ / _____

17. Has the subject had an Organ Transplant? No Yes Unknown

If Yes, specify organ: _____

18. Has the subject suffered any other medical conditions not mentioned above?

No Yes Unknown

If Yes, specify: _____