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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  Unknown

COPD?  No  Yes  Unknown

Cystic 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  Unknown

Congestive Heart Failure?  No  Yes  Unknown

Cardiomyopathy?  No  Yes  Unknown

Vascular Disease?  No  Yes  Unknown

Congenital 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  Unknown

Hepatitis B?  No  Yes  Unknown

Hepatitis 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  Unknown

Thyroid 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: \_\_\_\_\_