



Zika Virus Disease Case Investigation Form

Arboviral Diseases Branch
Version 3.1

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



FOR CDC USE ONLY

CDC R-number: _____

ZIKVID: _____

CDC staff initial: _____

Date form completed: ____/____/____

CDC investigating group: _____

Reporting Jurisdiction

Jurisdiction (state/territory): _____

Agency: _____

Contact Name: _____

Contact Phone: _____

Contact Position: _____

Contact Email: _____

Alternate Contact Name: _____

Alternate Contact Phone: _____

Demographic Information

State of residence: _____

State patient ID number: _____

Patient last name: _____

Patient first name: _____

Age: _____ Years Months Days

Sex: Male Female

Travel History

Dates of travel: _____

Country(s) visited: _____

Vaccination History

Previously vaccinated for: Yellow Fever Japanese Encephalitis Tick-borne Encephalitis

Cases of Special Interest

Please indicate if patient meets any of the following criteria:

Local vector-borne transmission

Yes No Suspect

Pregnant

Yes No Unknown

If yes: Current gestational week: _____

Gestational week at illness onset (if applicable): _____

Fetal loss

Yes No

If yes: Gestational week at time of fetal loss: _____

Microcephaly

Yes No Suspect

Guillain-Barre syndrome/acute flaccid paralysis

Yes No Suspect

Sexual transmission

Yes No Suspect

Blood/blood product transfusion transmission

Yes No Suspect

Organ/tissue transplant transmission

Yes No Suspect

Breastfeeding transmission

Yes No Suspect

Public reporting burden of this collection of information is estimated to average 10 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 (0920-1011)



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Illness Information	
Illness onset date: ____/____/____ <input type="checkbox"/> Hospitalized <input type="checkbox"/> Died	
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes: <input type="checkbox"/> Subjective fever <input type="checkbox"/> Measured fever (Maximum measured temperature: ____)
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes: Type: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other Pruritic: <input type="checkbox"/> Yes <input type="checkbox"/> No Distribution: _____
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Myalgia <input type="checkbox"/> Oral ulcers
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Vomiting <input type="checkbox"/> Hematospermia (for males)
<input type="checkbox"/> Headache	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Peripheral edema
Specimen Information	
Specimen 1 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen
Specimen 2 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen
Specimen 3 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen
Specimen 4 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen
Specimen 5 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen
Specimen 6 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen
Specimen 7 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Semen