

## Attachment 5: Zika Virus Disease Enhanced Surveillance – Hospitalization associated with Zika virus disease

Demographic Information	
Case ID (ArboNET): _____	Control for Case ID: _____
State of residence: _____	County of residence: _____
Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Est Date Delivery: ____/____/____ OR Last Menstrual Period: ____/____/____
Race ( <i>Select all appropriate</i> ): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Imported From: <input type="checkbox"/> Not Imported <input type="checkbox"/> Acquired Out of State <input type="checkbox"/> Acquired Out of Country <input type="checkbox"/> Unknown	
Country of Origin: _____	Travel dates: _____
State of Origin: _____	Travel dates: _____
Other possible exposures: <input type="checkbox"/> Sexual <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Blood products <input type="checkbox"/> Organs	
Past Medical History	
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Asthma/respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Autoimmune disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other immune deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Liver/hepatic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Kidney/renal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Seizure disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other neurologic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes: <input type="checkbox"/> Current <input type="checkbox"/> Past
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Intravenous drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes: <input type="checkbox"/> Current <input type="checkbox"/> Past
Other medically important condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
Pre-existing Medications and Treatments	

Public reporting burden of this collection of information is estimated to average 120 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-XXXX

Medications to treat hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Medications to treat coronary heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Medications to treat congestive heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other treatments for cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Medications that suppress the immune system	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Insulin or other meds to treat diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hemodialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other treatments for kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Oral or injected steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
<b>Clinical Information</b>	
Illness onset date: ____/____/____	
Clinical syndrome: <input type="checkbox"/> Febrile illness <input type="checkbox"/> Encephalitis/meningoencephalitis <input type="checkbox"/> Meningitis <input type="checkbox"/> Acute flaccid paralysis <input type="checkbox"/> Guillain-Barré syndrome <input type="checkbox"/> Other neuroinvasive presentation <input type="checkbox"/> Other clinical	
Case Status (ArboNET): <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Subjective <input type="checkbox"/> Measured (Max temperature: _____)
Chills/Rigors	<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 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 <input type="checkbox"/> Unk Distribution: _____
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Retro-orbital pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Oral ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nausea/Vomiting	<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
Arthralgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Paresis/Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Stiff Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Ataxia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Altered mental status	<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
Sore throat	<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
Lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Paresthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
<b>Outcomes</b>	
Emergency department	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hospitalized	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Admission: ____/____/____ Discharge: ____/____/____ Days hospitalized: _____ Multiple admissions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Number: _____
ICU	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Admission: ____/____/____ Discharge: ____/____/____ Days in intensive care: _____ Intubation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Admission diagnoses	Primary diagnosis or ICD 10: _____ Additional diagnoses: _____
<b>Outcomes (continued)</b>	
Discharge diagnoses	Primary diagnosis or ICD 10: _____ Additional diagnoses: _____
Died	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date of Death: ____/____/____ Causes of death: 1. _____ 2. _____ 3. _____
Discharged to rehab	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
<b>Treatments Administered During Hospitalization</b>	
Antimicrobials	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
Steroids/other immune modulating	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
Blood products	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Specify: _____
<b>Zika Virus Test Results</b>	
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial	
<b>Dengue Virus Test Results</b>	
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial	
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC	
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC	

Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial	Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial	Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial
Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial	Specimen collected: ____/____/____ Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Urine Test: <input type="checkbox"/> IgM <input type="checkbox"/> PRNT <input type="checkbox"/> PCR/NAT <input type="checkbox"/> IHC Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal Performing Lab: <input type="checkbox"/> CDC <input type="checkbox"/> State PH <input type="checkbox"/> Commercial

Laboratory Tests				
CBC performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">             Leukopenia (&lt;4,500)    <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk           </div> <div style="width: 45%;">             Nadir: ____ ; Date: ____/____/____           </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;">             Thrombocytopenia (&lt;150,000)    <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk           </div> <div style="width: 45%;">             Nadir: ____ ; Date: ____/____/____           </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;">             Leukocytosis (&gt;11,000)    <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk           </div> <div style="width: 45%;">             Max: ____ ; Date: ____/____/____           </div> </div>				
Abnormal liver enzymes		AST: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk    Max: ____; Date: ____/____/____ ALT: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk    Max: ____; Date: ____/____/____		
LP performed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date: ____/____/____ WBC: _____ RBC: _____ Protein: _____ Glucose: _____	Date: ____/____/____ WBC: _____ RBC: _____ Protein: _____ Glucose: _____	Date: ____/____/____ WBC: _____ RBC: _____ Protein: _____ Glucose: _____
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date: ____/____/____	Abnormal results: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

			If yes, describe: _____ _____
CT	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date: __/__/__	Abnormal results: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, describe: _____ _____
EMG/NCS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date: __/__/__	Abnormal results: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, describe: _____ _____
Other test	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date: __/__/__	Abnormal results: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, describe: _____ _____