



# Human Infection with Novel Influenza A Virus With Suspected Avian Source

Form Approved  
OMB No. 0920-0004

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(H7N2)  Influenza A(H7N3)  Influenza A(H7N9)  Other, please describe \_\_\_\_\_  Unknown subtype

### 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: (check  White  Asian  American Indian/Alaska Native  Black  Native Hawaiian/Other Pacific Islander 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)?  
 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

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 (0920-0004).



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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) \_\_\_\_\_
  - 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



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## Epidemiologic Risk Factors

45. In the 10 days prior to illness onset, did the patient travel outside of his/her usual area?  Yes  No (skip to Q.49)  Unknown (skip to Q.49)
46. When and where did the patient travel?  
**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 traveled  Yes, with household members  Yes, with non-household members  Unknown
48. Please describe the details of the trip \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Risk Factors— Livestock Animals

49. In the 10 days before becoming ill, did the patient attend an agricultural fair/event?  
 Yes (specify name, if >1 fair, please describe in the notes section \_\_\_\_\_)  No (skip to Q.51)  Unknown (skip to Q.51)
50. In the 10 days before becoming ill, on what days did the patient attend an agricultural fair/event (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  
 8 days before illness onset  9 days before illness onset  10 days before illness onset
51. In the 10 days before becoming ill, did the patient visit a live animal market?  
 Yes, specify name \_\_\_\_\_  No (skip to Q.54)  Unknown (skip to Q.54)
52. Did the patient or their household members handle or purchase any live or freshly killed poultry from the market?  
 Yes  No (skip to Q.54)  Unknown (skip to Q.54)
53. In the 10 days before becoming ill, on what days did the patient visit a 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  
 8 days before illness onset  9 days before illness onset  10 days before illness onset
54. In the 10 days before becoming ill, did the patient have **ANY** contact with livestock animals like poultry or pigs?  
 Yes  No (skip to Q.75)  Unknown (skip to Q.75)
55. What type(s) of animals did the patient have **ANY** contact with (check all that apply)?  
 Horses  Cows  Poultry  Sheep  Goats  Pigs/hogs  Other \_\_\_\_\_
56. Where did the contact occur (check all that apply)?  
 Home  Commercial farm  Agricultural fair or event  Live animal market  Petting zoo  Veterinary contact  
 Slaughterhouse  Other \_\_\_\_\_

## Risk Factors—Poultry

**Please answer Q.57–74 if ANY contact with poultry identified above. If no contact identified, please skip to Q.75.**

57. In the 10 days before becoming ill, did the patient have **DIRECT** (touch or handle) contact with poultry?  
 Yes  No (skip to Q.63)  Unknown (skip to Q.63)
58. Where did the **DIRECT** contact with poultry occur (check all that apply)?  
 Home  Commercial poultry farm  Agricultural fair or event  Live animal market  Petting zoo  Veterinary contact  
 Slaughterhouse  Other \_\_\_\_\_
59. Did the patient touch or handle any poultry in the 10 days before becoming ill?  
 Yes  No  Unknown
60. Did the patient bathe or wash any poultry in the 10 days before becoming ill?  
 Yes  No  Unknown
61. Did the patient slaughter or de-feather (pluck) any poultry in the 10 days before becoming ill?  
 Yes  No  Unknown
62. What type(s) of poultry did the patient have **DIRECT** contact with (check all that apply)?  
 Chickens  Turkeys  Geese  Pheasants  Ducks  Ostriches  Emus  Pigeons  
 Other \_\_\_\_\_
63. In the 10 days before becoming ill, did the patient have **INDIRECT** (walk through an area containing or come within 6 feet of) contact with poultry?  
 Yes  No (skip to Q.71)  Unknown (skip to Q.71)



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64. Where did the **INDIRECT** contact with poultry occur (check all that apply)?  
 Home    Commercial poultry farm    Agricultural fair or event    Live animal market    Petting zoo    Veterinary contact  
 Slaughterhouse    Other \_\_\_\_\_
65. Did the patient clean any poultry pens/houses in the 10 days before becoming ill?  
 Yes    No    Unknown
66. Did the patient feed or water any poultry in the 10 days before becoming ill?  
 Yes    No    Unknown
67. Did the patient have direct contact with surfaces contaminated by poultry feces or poultry parts (carcasses, internal organs, etc.) in the 10 days before becoming ill?  
 Yes    No    Unknown
68. Did the patient participate in the culling of any flocks?  
 Yes    No (skip to Q.70)    Unknown (skip to Q.70)
69. What measures did the patient use to protect himself/herself during the culling (check all that apply)?  
 None    Facemask    Respirators    Hand gloves    Eyeglasses    Gowns    Boots    Unknown  
 Other \_\_\_\_\_
70. What type(s) of poultry did the patient have **INDIRECT** contact with (check all that apply)?  
 Chickens    Turkeys    Geese    Pheasants    Ducks    Ostriches    Emus    Pigeons  
 Other \_\_\_\_\_
71. In the 10 days before becoming ill, on what days did the patient have **ANY** contact (direct, indirect, or both) with poultry (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  
 8 days before illness onset    9 days before illness onset    10 days before illness onset
72. From Q. 71, what was the total number of different days the patient reported **ANY** poultry contact (direct, indirect, or both)? \_\_\_\_\_ days
73. Did the patient report **ANY** contact (direct, indirect, or both) with any ill-appearing poultry in the 10 days before becoming ill?  
 Yes, specify \_\_\_\_\_    No    Unknown
74. Did the patient report **ANY** contact (direct, indirect, or both) with dead poultry in the 10 days before becoming ill?  
 Yes, specify \_\_\_\_\_    No    Unknown

### Risk Factors—Household poultry practices

75. Were poultry raised on the patient's property?  
 Yes    No (skip to Q.83)    Unknown (skip to Q.83)
76. Where were the poultry kept (check all that apply)?  
 In patient's basement or garage    Inside patient's house/living space    Open-air poultry pen or poultry house  
 Enclosed poultry pen or poultry house    Other enclosure/cage outside the patient's house    Other \_\_\_\_\_
77. What type(s) of poultry did the patient raise (check all that apply)? Please specify number of each type raised.  
 Chickens \_\_\_#    Turkeys \_\_\_#    Geese \_\_\_#    Pheasants \_\_\_#    Ducks \_\_\_#    Ostriches \_\_\_#  
 Emus \_\_\_#    Pigeons \_\_\_#    Other \_\_\_\_\_#
78. Did the patient's household have any recent ill-appearing poultry?  
 Yes    No    Unknown
79. Did the patient's household have any recent poultry die-offs?  
 Yes    No (skip to Q.83)    Unknown (skip to Q.83)
80. Please indicate the percent of the flock that died. \_\_\_\_\_%
81. When did the die-off begin and end?   Begin date: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)   End date: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)
82. Was the flock culled?  
 Yes (date \_\_\_/\_\_\_/\_\_\_ MM/DD/YY)    No    Unknown
83. Did the patient have contact with any eggs from a private flock (i.e. not store bought or commercial) in the 10 days before becoming ill?  
 Yes    No    Unknown
84. Did the patient consume raw or undercooked poultry in the 10 days before becoming ill?  
 Yes    No    Unknown
85. Does anyone else in the household own, keep or care for poultry in a location other than the patient's property?  
 Yes, specify \_\_\_\_\_    No    Unknown
86. Were there any recent reports of sick or dead poultry in the case patient's area?  
 Yes, specify \_\_\_\_\_    No    Unknown

### Risk Factors—Wild/Migratory birds

87. Did the patient visit any areas where wild/migratory birds (e.g. herons, gulls, falcons, wild ducks, geese, or swans) are present?  
 Yes, specify location \_\_\_\_\_    No    Unknown



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88. In the 10 days before illness onset, did the patient have **ANY** contact with wild/migratory birds?  
 Yes       No (skip to Q.93)       Unknown (skip to Q.93)
89. In the 10 days before illness onset, did the patient have any **DIRECT** contact (touch or handle) with any wild/migratory birds?  
 Yes, specify type of bird(s) \_\_\_\_\_  No       Unknown
90. In the 10 days before becoming ill, did the patient have **INDIRECT** contact (walk through an area containing or come within 6 feet of) any wild/migratory birds?  
 Yes, specify type of bird(s) \_\_\_\_\_  No       Unknown
91. Were any of the wild/migratory birds that the patient had **ANY** contact with sick or dying?  
 Yes, specify \_\_\_\_\_  No       Unknown
92. In the 10 days before becoming ill, on what days did the patient have **ANY** contact (direct, indirect, or both) with wild birds (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  
 8 days before illness onset     9 days before illness onset     10 days before illness onset

### Risk Factors—Other Animals

93. In the 10 days before becoming ill, did the patient have contact with an animal other than poultry or livestock (e.g. a cat or dog) that had a confirmed influenza virus infection??  
 Yes       No       Unknown

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

94. Does the patient reside in an institutional or group setting (e.g. nursing home, boarding school, college dormitory)?  
 Yes (skip to Q.96)     No       Unknown (skip to Q.96)
95. 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 +/- 10 days from case patient's onset?	Date of illness onset	If HH member <b>ILL</b>		If HH member <b>NOT ILL</b>
							Any bird contact ≤10 days before his/her onset?	Attend fair/live market ≤10 days before his/her onset?	Bird contact or fair/market visit ≤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

96. In the 10 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.98)       Unknown (skip to Q.98)
97. Approximately how many children are in the patient's class or room at the child care facility? \_\_\_\_\_
98. In the 10 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.100)       Unknown (skip to Q.100)
99. Approximately how many students are in the patient's class at the school? \_\_\_\_\_ children
100. In the 10 days before or after the patient became ill, did anyone else in the patient's household(s) work at/attend a child care facility or school?  
 Yes       No (skip to Q.102)       Unknown (skip to Q.102)
101. List ID numbers from Q.95 (the table above) for household members working at or attending a child care facility or school:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
102. Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?  
 Yes (date \_\_\_\_/\_\_\_\_/\_\_\_\_ MM/DD/YY)       No       Unknown
103. In the 10 days before or after becoming ill, did the patient work in or volunteer at a healthcare facility or setting?  
 Yes       No (skip to Q.106)       Unknown (skip to Q.106)
104. Specify healthcare facility job/role:  
 Physician     Nurse     Administration staff     Housekeeping     Patient transport     Volunteer     Other \_\_\_\_\_
105. Did the patient have direct patient contact while working or volunteering at a healthcare facility?  
 Yes       No       Unknown



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106. In the 10 days before becoming ill, was the patient in a hospital for any reason (i.e., visiting, working, or for treatment)?

- Yes     No     Unknown

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

107. In the 10 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 \_\_\_\_\_

108. In the 10 days before becoming ill, did the patient have close contact (e.g. caring for, speaking with, or touching) with anyone other than their household members who routinely has contact with birds (poultry or wild)?

- Yes     No     Unknown

109. In the 10 days before becoming ill, did the patient have close contact (e.g. caring for, speaking with, or touching) with anyone who reported travel to a country with avian influenza cases (e.g. Indonesia, Egypt, Viet Nam, China, Hong Kong, Cambodia, Thailand)?

- Yes     No     Unknown

110. 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 10 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 bird contact or fair/live market visits ≤10 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	

111. 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 bird contact or fair/live market visits ≤10 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	

112. 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			

113. Any additional comments or notes (e.g. 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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**This is the end of the case report form. Thank you very much for your time.**

**Please fax completed forms to 1.888.232.1322**

**If you have any questions please feel free to contact the Epidemiology and Prevention Branch at 404.639.3747.**