State/local ID: \_\_\_\_\_\_\_\_\_ CDC ID:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dash sticker:

Household ID: \_\_\_\_\_\_\_\_\_Cluster ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_

:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Interviewer Information** |

Date interview completed: / / (MM/DD/YYYY) Date reported to health department: / / (MM/DD/YYYY)

Interviewer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Local Health Department\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is providing information for this form?

Case-patient

Other, specify name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to case patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case-patient primary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was this form administered via a translator? □ Yes □ No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Case-Patient Information** | | | | | |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Zip:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone No. 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone No. 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other point of contact name:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other point of contact Phone: Relationship to case patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Date reported to health department: / / (MM/DD/YYYY)  At the time of this report, is this patient a 2019-nCoV laboratory-confirmed case?  Yes No | | | |
| **Demographic information** | | | | | |

1. Date of birth: / / (MM/DD/YYYY)
2. Age: \_\_\_\_\_\_\_  years  months
3. Current residence: Country: \_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Living situation at time of illness:  Private residence  Military base  Shelter  Nursing home/long-term healthcare facility  School dormitory  Homeless  Detention facility  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Ethnicity:  Hispanic or Latino  Not Hispanic or Latino
6. Race (Select all that apply): White Asian American Indian/Alaska Native Black or African American Native Hawaiian/Other Pacific Islander
7. Sex:  Male Female
8. Is the patient a healthcare worker?  Yes  No  Unknown
9. Occupation

|  |
| --- |
| **Clinical Presentation and Course** |

1. Date of first symptom onset \_\_/\_\_\_/\_\_\_\_\_ (MM/DD/YYYY)
2. Does the patient still have symptoms?

Yes No Unknown

1. When did the patient feel back to normal? / / (MM/DD/YYYY)
2. During this illness, did the patient experience any of the following?

| **Symptom** | **Symptom Present?** | **Date of Onset (MM/DD/YY)** | **Duration (no. of days)** |
| --- | --- | --- | --- |
| Fever >100.4F (38C) | Yes No Unk |  |  |
| Highest temp\_\_\_\_\_\_\_\_ °F |  |  |  |
| Subjective fever (felt feverish) | Yes No Unk |  |  |
| Chills | Yes No Unk |  |  |
| Cough (new onset or worsening of chronic cough) | Yes No Unk |  |  |
| Dry | Yes No Unk |  |  |
| Productive | Yes No Unk |  |  |
| Bloody sputum (hemoptysis) | Yes No Unk |  |  |
| Sore throat | Yes No Unk |  |  |
| Wheezing | Yes No Unk |  |  |
| Shortness of breath (dyspnea) | Yes No Unk |  |  |
| Swollen lymph nodes (lymphadenopathy) | Yes No Unk |  |  |
| Apnea | Yes No Unk |  |  |
| Runny nose (rhinorrhea) | Yes No Unk |  |  |
| Eye redness (conjunctivitis) | Yes No Unk |  |  |
| Ear pain | Yes No Unk |  |  |
| Rash | Yes No Unk |  |  |
| Abdominal pain | Yes No Unk |  |  |
| Nausea | Yes No Unk |  |  |
| Vomiting | Yes No Unk |  |  |
| Diarrhea (>3 loose stools/day) | Yes No Unk |  |  |
| Chest Pain | Yes No Unk |  |  |
| Muscle aches (myalgia) | Yes No Unk |  |  |
| Headache | Yes No Unk |  |  |
| Dizziness | Yes No Unk |  |  |
| Fatigue | Yes No Unk |  |  |
| Altered Mental Status | Yes No Unk |  |  |
| Seizures | Yes No Unk |  |  |
| Other, specify: | Yes No Unk |  |  |
| Other, specify: | Yes No Unk |  |  |

1. Did the patient seek medical care for this illness? Yes No Unk

If, yes which type of facility: (Check all that apply) Outpatient clinic Urgent Care Emergency department Hospital

1. Was the patient hospitalized for the illness? (if yes, complete hospital form)  Yes  No Unknown
2. Is the patient still hospitalized for this illness?  Yes  No Unknown
3. Did the patient have an abnormal chest x-ray? Yes No Unk Not performed
4. Did the patient receive supplemental oxygen? Yes No Unk
5. Was the patient admitted to the intensive care unit (ICU)? Yes No Unk
6. Did the patient receive mechanical ventilation? Yes No Unk
7. Was the patient on extra corporeal membranous oxygen (ECMO)? Yes No Unk
8. Patient outcome due to illness: Survived Died Unk

|  |
| --- |
| **Medical History** |

1. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chronic Lung Disease | | | | |
| Asthma/reactive airway disease | Yes | No | Unknown |  |
| Other chronic lung disease | Yes | No | Unknown | (If YES, specify) |
| Diabetes Mellitus |  |  |  |  |
| Diabetes Mellitus Type 1 | Yes | No | Unknown |  |
| Diabetes Mellitus Type 2 | Yes | No | Unknown |  |
| Hypertension | Yes | No | Unknown |  |
| Chronic heart or cardiovascular disease | Yes | No | Unknown | (If YES, specify) |
| Chronic kidney disease | Yes | No | Unknown | (If YES, specify) |
| Liver disease | Yes | No | Unknown | (If YES, specify) |
| Non-cancer immunosuppressive condition or treatment | Yes | No | Unknown | (If YES, specify) |
| Cancer chemotherapy in past 12 months | Yes | No | Unknown | (If YES, specify) |
| Neurologic/neurodevelopmental disorder | Yes | No | Unknown | (If YES, specify) |
| Other, specify: | Yes | No | Unknown | (If YES, specify) |

1. Was patient pregnant at illness onset?

Yes, weeks pregnant at onset No Unknown

1. Was patient ≤6 weeks postpartum at illness onset?

Yes, postpartum (delivery date) \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY) No Unknown

1. Has the patient ever smoked? Yes No Unknown
2. Does the patient currently smoke? Yes No Unknown
3. Does the patient currently smoke e-cigarettes? Yes No Unknown

|  |
| --- |
| **2019-nCoV Laboratory Testing** *(For each specimen type, please report earliest positive specimen, or earliest collected if all negative)* |

|  |  |  |
| --- | --- | --- |
| **Specimen Type** | **Date of Collection** | **Test Result** |
| NP Swab | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| OP Swab | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Sputum | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Bronchoalveolar lavage (BAL) fluid | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Tracheal fluid | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Stool | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Urine | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Serum | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |
| Other, specify\_\_\_\_ | \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY) | Positive  Negative  Indeterminate Pending |

|  |
| --- |
| **Exposure** |

1. In the **14 DAYS prior to illness**, did the case-patient travel outside of the United States? Yes No Unknown

If yes, city\_\_\_\_\_\_\_\_\_\_\_ state/province \_\_\_\_\_\_\_\_\_ country\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

If yes, city\_\_\_\_\_\_\_\_\_\_\_ state/province \_\_\_\_\_\_\_\_\_ country\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

If yes, city\_\_\_\_\_\_\_\_\_\_\_ state/province \_\_\_\_\_\_\_\_\_ country\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

1. In the **14 DAYS prior to illness**, did the case-patient travel outside of their state of residence? Yes No Unknown

If yes, city\_\_\_\_\_\_\_\_\_\_\_ county \_\_\_\_\_\_\_\_\_ state\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

If yes, city\_\_\_\_\_\_\_\_\_\_\_ county \_\_\_\_\_\_\_\_\_ state\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

If yes, city\_\_\_\_\_\_\_\_\_\_\_ county \_\_\_\_\_\_\_\_\_ state\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: (MM/DD/YYYY) \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

1. In the **14 DAYS prior to illness**, did the patient:

|  |  |  |  |
| --- | --- | --- | --- |
| Have close contact with a confirmed 2019-nCoV case-patient? | Yes | No | Unknown |
| Have close contact with any household members, friends, acquaintances, or co-workers who had symptoms like the case-patient’s? | Yes | No | Unknown |
| Visit a live animal market? If yes, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Unknown |
| Work or volunteer in a healthcare setting? | Yes | No | Unknown |
| Visit a healthcare setting? | Yes | No | Unknown |

1. Was this patient under active or passive monitoring following exposure to a confirmed 2019-nCoV case-patient?

Yes No Unknown