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