Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019-Novel Coronavirus (2019-nCoV) Case Report Form

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

10. Date of first symptom onset ___/___/_____(MM/DD/YYYY)
11. Does the patient still have symptoms?
    ☐ Yes ☐ No ☐ Unknown
12. When did the patient feel back to normal?____/_____/_____(MM/DD/YYYY)
13. During this illness, did the patient experience any of the following?

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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		

14. 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
15. Was the patient hospitalized for the illness? (if yes, complete hospital form) ☐ Yes ☐ No ☐Unknown
16. Is the patient still hospitalized for this illness? ☐ Yes ☐ No ☐Unknown
17. Did the patient have an abnormal chest x-ray? ☐Yes ☐No ☐Unk ☐Not performed
18. Did the patient receive supplemental oxygen? ☐Yes ☐No ☐Unk
19. Was the patient admitted to the intensive care unit (ICU)? ☐Yes ☐No ☐Unk
20. Did the patient receive mechanical ventilation? ☐Yes ☐No ☐Unk
21. Was the patient on extra corporeal membranous oxygen (ECMO)? ☐Yes ☐No ☐Unk
22. Patient outcome due to illness: ☐Survived ☐Died ☐Unk

Medical History

23. 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) _____

24. Was patient pregnant at illness onset?
☐ Yes, weeks pregnant at onset_____ ☐ No ☐ Unknown
25. Was patient ≤6 weeks postpartum at illness onset?
☐ Yes, postpartum (delivery date) ___/___/___ (MM/DD/YYYY) ☐ No ☐ Unknown

26. Has the patient ever smoked? ☐ Yes ☐ No ☐ Unknown
27. Does the patient currently smoke? ☐ Yes ☐ No ☐ Unknown
28. 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

29. 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) ____/____/____ - ____/____/____
30. 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) ____/____/____ - ____/____/____
31. 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

32. Was this patient under active or passive monitoring following exposure to a confirmed 2019-nCoV case-patient?
☐ Yes ☐ No ☐ Unknown