



# 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Demographic information

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

### Clinical Presentation and Course

- Date of first symptom onset / / (MM/DD/YYYY)
- Does the patient still have symptoms?  
 Yes  No  Unknown
- When did the patient feel back to normal? / / (MM/DD/YYYY)
- During this illness, did the patient experience any of the following?

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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



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Symptom	Symptom Present?	Date of Onset (MM/DD/YY)	Duration (no. of days)
Fever >100.4F (38C)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Highest temp _____ °F			
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Dry	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Productive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Bloody sputum (hemoptysis)	<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		
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Swollen lymph nodes (lymphadenopathy)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Eye redness (conjunctivitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Ear pain	<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		
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Diarrhea (>3 loose stools/day)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Muscle aches (myalgia)	<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		
Dizziness	<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		
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		
Other, specify:	<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		

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.

<b>Chronic Lung Disease</b>				
Asthma/reactive airway disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other chronic lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
<b>Diabetes Mellitus</b>				
Diabetes Mellitus Type 1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Diabetes Mellitus Type 2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Hypertension</b>				
Chronic heart or cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Chronic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____



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Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Non-cancer immunosuppressive condition or treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Cancer chemotherapy in past 12 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Neurologic/neurodevelopmental disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Other, specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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

<b>2019-nCoV Laboratory Testing</b>		<i>(For each specimen type, please report earliest positive specimen, or earliest collected if all negative)</i>			
Specimen Type	Date of Collection	Test Result			
NP Swab	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
OP Swab	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Sputum	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Bronchoalveolar lavage (BAL) fluid	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Tracheal fluid	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Stool	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Urine	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Serum	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Other, specify _____	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Have close contact with any household members, friends, acquaintances, or co-workers who had symptoms like the case-patient's?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Visit a live animal market? If yes, specify _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Work or volunteer in a healthcare setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Visit a healthcare setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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