Chronic Q Fever Enhanced Surveillance

Thank you for consulting with CDC; please complete the information below to help us learn more about the clinical manifestations of chronic Q fever in the United States.

Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/20XX

The following enhanced chronic Q fever clinical surveillance tool was developed to gather more detailed and specific clinical data on chronic Q fever to better understand its presentation, management, and long-term outcomes. This information will allow for better characterization of chronic Q fever in the United States.

Your participation in this survey is strictly voluntary and you may stop at any time. All information collected will remain anonymous; we will not collect any personally identifiable information, such as your patient's name or contact information. There are no negative consequences to you should you decline to participate or not complete the survey in its entirety. You may continue to consult with CDC's Rickettsial Zoonoses Branch regardless of your participation in enhanced surveillance.

This survey should take you approximately 20 minutes to complete.

If you have any questions or concerns about completing this survey, please contact: 404-639-1075 or rzbepidiag@cdc.gov.

The Rickettsial Zoonoses Branch thanks you for your time and involvement.

Demographics

When was this patient first diagnosed with chronic Q fever?

_____
(YYYY; If unknown, leave blank.)

Patient's age at first diagnosis

_____
(in years)

Sex of patient ◯ Male ◯ Female ◯ Not specified

State of Residence

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ District of Columbia
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ Puerto Rico
- ◯ U.S. Virgin Islands
- ◯ Guam
- ◯ American Samoa
- ◯ Northern Mariana Islands

Race	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown (select all that apply)
Ethnicity	◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown

Acute Q fever history

Was this patient previously diagnosed with acute Q fever?	◯ Yes ◯ No ◯ Unknown
Is the date of acute Q fever diagnosis known?	◯ Yes ◯ No
Year of acute Q fever diagnosis.	_____ (YYYY)
How was the initial diagnosis made?	☐ PCR ☐ Paired Serology ☐ Single serology ☐ Other ☐ Unknown (Select all that apply.)
If other diagnostic used, specify.	_____
Was the patient treated for acute Q fever?	◯ Yes ◯ No ◯ Unknown
What medication(s) was/were used?	☐ Doxycycline ☐ Trimethoprim/sulfamethoxazole ☐ Other ☐ Unknown (Select all that apply.)
Pleas specify what other antibiotics were prescribed?	_____ (Use the common name for the drug or chemical, not trade name.)
How long was the patient on the medication for treatment of acute Q fever?	_____ (Number of days.)
Was this patient pregnant at the time of acute Q fever diagnosis?	◯ Yes ◯ No ◯ Unknown
In which trimester did the symptoms begin?	◯ 1st (weeks 1-12) ◯ 2nd (weeks 13-28) ◯ 3rd (weeks 29-42) ◯ Unknown
Was the patient treated during pregnancy?	◯ Yes ◯ No ◯ Unknown
At what week gestation did treatment begin?	_____ (Week number)
Is the patient still receiving treatment?	◯ Yes ◯ No ◯ Unknown

How long was the patient on medication before treatment was discontinued?

_____
(Number of weeks.)

What antibiotics are/were used?

☐ Trimethoprim/sulfamethoxazole
☐ Other
☐ Unknown

If other antibiotic use, specify.

_____
(Use the common name for the drug or chemical, not trade name.)

Did this patient develop placentitis?

◯ Yes ◯ No ◯ Unknown

Did this patient develop any of the following complications of pregnancy?

☐ Intrauterine growth restriction (IUGR)
☐ Stillbirth
☐ Miscarriage
☐ Premature delivery
☐ Other
☐ No complications
☐ Unknown
(Select all that apply.)

If other complication of pregnancy, please specify.

_____

Where any of the following newborn complications present?

☐ Malformations
☐ Hyperbilirubinemia
☐ Kernicterus
☐ Other
☐ No complications
☐ Unknown
(Select all that apply.)

If malformations, please specify types.

_____

What other newborn complications were present?

_____

What was the gestational age at birth?

_____
(Weeks)

What was the weight at birth?

_____
(in pounds)

Risk Factors

Did this patient have a history of any of the following cardiovascular conditions?

- ☐ No history of cardiovascular conditions
- ☐ Rheumatic heart disease
- ☐ Aortic valve stenosis
- ☐ Aortic valve prolapse
- ☐ Aortic valve regurgitation
- ☐ Mitral valve stenosis
- ☐ Mitral valve prolapse
- ☐ Mitral valve regurgitation
- ☐ Pulmonic valve stenosis
- ☐ Pulmonic valve prolapse
- ☐ Pulmonic valve regurgitation
- ☐ Tricuspid valve stenosis
- ☐ Tricuspid valve prolapse
- ☐ Tricuspid valve regurgitation
- ☐ Prosthetic valve
- ☐ Aneurysm
- ☐ Vascular graft/stent
- ☐ Atrial septal defect
- ☐ Patent ductus arteriosus
- ☐ Ventricular septal defect
- ☐ Tetralogy of Fallot
- ☐ Other congenital heart defect
- ☐ Other heart valve problem
- ☐ Unknown

(Check all that apply.)

Which valve was replaced?

- ☐ Aortic
- ☐ Mitral
- ☐ Pulmonic
- ☐ Tricuspid
- ☐ Unknown

(Select all that apply)

Year of most recent replacement.

_____

(YYYY)

What type of valve replacement did the patient receive?

- ◯ Manufactured mechanical valve
- ◯ Human donor valve
- ◯ Bioprosthetic - bovine
- ◯ Bioprosthetic - porcine
- ◯ Other
- ◯ Unknown

Please specify other valve replacement received.

_____

History of >1 valve replacement? ◯ Yes ◯ No ◯ Unknown

Please specify other congenital heart defect.

_____

Please specify other heart valve problem.

_____

Clinical Findings

What clinical signs and symptoms has the patient exhibited?

- ☐ Relapsing fever
- ☐ Chills
- ☐ Weight loss
- ☐ Night sweats
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Hepatosplenomegaly
- ☐ Other
- ☐ Unknown

(Select all that apply.)

Please specify what other clinical signs and symptoms the patient has exhibited.

_____

Endocarditis

Did this patient have culture negative endocarditis?	◯ Yes ◯ No ◯ Unknown
Please specify affected valve(s)	☐ Aortic valve ☐ Mitral valve ☐ Pulmonary valve ☐ Tricuspid valve ☐ Unknown (Select all that apply.)
What imaging technologies were used to diagnose endocarditis?	☐ Transthoracic echocardiogram (TTE) ☐ Transesophageal echocardiogram (TEE) ☐ PET CT Scan ☐ CT Scan ☐ MRI ☐ Other ☐ Unknown (Select all that apply.)
Please specify what other imaging was/were used to diagnose endocarditis.	_____
Was the infected valve removed?	◯ Yes ◯ No ◯ Unknown
Please specify the year of valve removal.	_____ (YYYY)
Was the valve tested for the presence of Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Which testing method was used on the valve sample?	☐ PCR ☐ IHC ☐ Culture ☐ Unknown (Select all that apply.)
What were the diagnostic results?	◯ Positive ◯ Negative/undetermined ◯ Unknown

Vascular infection

Did this patient have a vascular infection (i.e. infection of vascular graft, stent, or aneurysm) caused by Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Please specify which type of vascular infection.	☐ Vascular graft ☐ Stent ☐ Aneurysm ☐ Other ☐ Unknown
Please specify what other type of vascular infection was present.	_____
Please specify location of infection.	☐ Abdominal aorta ☐ Thoracic aorta ☐ Other ☐ Unknown
Please specify the other location of infection.	_____
What year was the now infected graft/stent originally placed?	_____ (YYYY)
Was infected graft/stent removed or aneurysm repaired?	◯ Yes ◯ No ◯ Unknown
Please specify the year of removal or repair surgery.	_____ (YYYY)
Was the vascular infection tested for presence of Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Which testing method was used to on the vascular infection sample?	☐ PCR ☐ IHC ☐ Culture ☐ Unknown (Select all that apply.)
What were the diagnostic results?	◯ Positive ◯ Negative/undetermined ◯ Unknown

Osteoarticular infection

Did this patient have an osteoarticular infection (e.g. osteomyelitis or spondylodiscitis) caused by Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Please specify location of osteoarticular infection.	_____
Was this a native joint?	◯ Yes ◯ No ◯ Unknown ◯ Not applicable
Was surgical debridement of the diseased tissue and bone performed?	◯ Yes ◯ No ◯ Unknown
Specify the year of most recent debridement.	_____ (YYYY)
During the debridement, was any tissue tested for presence of Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Which testing method was used on the debrided tissue?	☐ PCR ☐ IHC ☐ Culture ☐ Unknown (Select all that apply.)
What were the diagnostic results?	◯ Positive ◯ Negative/undetermined ◯ Unknown

Granulomatous hepatitis

Did this patient have evidence of granulomatous hepatitis?	◯ Yes ◯ No ◯ Unknown
Which liver function tests were elevated?	☐ Alk Phos ☐ ALT ☐ AST ☐ LDH ☐ Bilirubin ☐ Albumin ☐ GGT (Select all that apply.)
Which imaging techologies were used to diagnose hepatitis?	☐ Ultrasound ☐ MRI ☐ MRE (elastography) ☐ CT ☐ Other ☐ No imaging performed (Select all that apply)
What other imaging technology was used to diagnose hepatitis?	_____
Was a liver biopsy performed?	◯ Yes ◯ No ◯ Unknown
What year was the liver biopsy performed?	_____ (YYYY)
Was the biopsy tested for presence of Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Which testing method was used on the liver biopsy?	☐ PCR ☐ IHC ☐ Culture ☐ Unknown (Select all that apply.)
What were the diagnostic results?	◯ Positive ◯ Negative/undetermined ◯ Unknown

Lymphadenopathy

Did this patient develop lymphadenopathy?	◯ Yes ◯ No ◯ Unknown
Please specify location of lymphadenopathy(s)	☐ Cervical ☐ Supraclavicular ☐ Axillary ☐ Perihilar ☐ Mediastinal ☐ Mesenteric ☐ Inguinal ☐ Popliteal ☐ Other (Select all that apply.)
If other location of lymphadenopathy, please specify.	_____
Was a lymph node biopsy performed?	◯ Yes ◯ No ◯ Unknown
Was the biopsy tested for presence of Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
Which testing method was used on the lymph node biopsy?	☐ PCR ☐ IHC ☐ Culture ☐ Unknown (Select all that apply.)
What were the diagnostic results?	◯ Positive ◯ Negative/Undetermined ◯ Unknown

Additional complications

Did this patient develop any of the following complications?	☐ Psoas abscess ☐ Cardiac abscess ☐ Empyema or other pulmonary abscess ☐ Other abscess ☐ Ruptured aneurism ☐ None of the above ☐ Unknown (Select all that apply.)
Please specify the location of the other abscess.	_____
Was medical intervention performed?	◯ Yes ◯ No ◯ Unknown
What interventions were performed?	☐ Incision and drainage ☐ Marsupialization ☐ Indwelling drain ☐ Other ☐ Unknown (Select all that apply.)
Please specify what other intervention was performed.	_____
What year was the intervention performed?	_____ (YYYY)
Was any material from the abscess or rupture tested for Coxiella burnetii?	◯ Yes ◯ No ◯ Unknown
What was the method used to test material from the abscess?	☐ PCR ☐ IHC ☐ Culture ☐ Unknown (Select all that apply.)
What was the result of testing?	◯ Positive ◯ Negative/undetermined ◯ Unknown
Did this patient develop an embolic stroke or infarct?	◯ Yes ◯ No ◯ Unknown
Please specify the location of the embolic stroke or infarct.	_____
Was this patient admitted to the hospital for chronic Q fever?	◯ Yes ◯ No ◯ Unknown
Please provide the number of times the patient was hospitalized at least overnight for complications of chronic Q fever since the initial chronic Q diagnosis	_____ (# of hospitalizations)

Antibiotics

Which antibiotics did the patient receive?

- ☐ Doxycycline
- ☐ Hydroxychloroquine
- ☐ Other
- ☐ None
- ☐ Unknown

(Select all that apply)

Please specify what other antibiotics is/was the patient on.

_____

(Use the common name for the drug or chemical, not trade name.)

How many months has the patient been on antibiotic therapy?

_____

(Number of Months)

Has the patient completed antibiotic therapy?

◯ Yes ◯ No ◯ Unknown

Did the patient develop any of the following side effects or complications from antibiotic therapy?

- ☐ Nausea/other GI upset
- ☐ Retinal damage
- ☐ QT prolongation
- ☐ Photosensitivity
- ☐ Irreversible skin pigmentation
- ☐ Other
- ☐ None
- ☐ Unknown

(Select all that apply.)

Please specify what other side effects or complications the patient developed from antibiotic therapy.

_____

Was the patient taken off any antibiotic during treatment due to side effects?

◯ Yes ◯ No ◯ Unknown

Which medication(s) were stopped?

- ☐ Doxycycline
- ☐ Hydroxychloroquine
- ☐ Other

(Select all that apply)

What other antibiotic was stopped?

_____

(Use the common name for the drug or chemical, not trade name.)

What were the side effects that led to the medication being discontinued?

- ☐ Nausea/other GI upset
- ☐ Retinal damage
- ☐ QT prolongation
- ☐ Photosensitivity
- ☐ Irreversible skin pigmentation
- ☐ Fatigue
- ☐ Other

(Select all that apply.)

Please specify other side effects that led to medication to medication being discontinued.

_____

Serology

On average, how frequently are/were Q fever serologies collected from the patient?	_____ (Average months (#))
What was the Phase 1 IgG serology titer value at the initial chronic Q diagnosis?	_____ (Record the only reciprocal titer (e.g. 64, 128, 256))
What was the Phase 2 IgG serology titer value at the initial chronic Q diagnosis?	_____ (Record the only reciprocal titer (e.g. 64, 128, 256))
What was the most recent Phase 1 IgG titer value recorded?	_____ (Record the only reciprocal titer (e.g. 64, 128, 256))
What was the most recent Phase 2 IgG titer value recorded?	_____ (Record the only reciprocal titer (e.g. 64, 128, 256))
How many weeks ago was the most recent serology collected?	_____ (Number of weeks)
At any point during treatment, has a four-fold reduction in Phase 1 titers been observed?	◯ Yes ◯ No ◯ Unknown

Outcome	
Did the patient die from complications of this illness?	◯ Yes ◯ No ◯ Unknown
What was the cause of death per death certificate?	_____