State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Source Case state/local ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

State/local health dept.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Source Case CDC 2019-nCoV ID b: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact ID a: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact 2019-nCoV IDc: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case 0023CA has contacts 0023CA-001 and 0023CA-002
2. Complete with ID of the associated confirmed case who identified this contact
3. To be assigned at CDC

**Interviewer instructions: prior to interview with contact, please note the following information about the confirmed 2019-nCoV case that identified this contact***:*

**……………PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……………………**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **……………PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……………………**  Case Identification number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  |

## Demographic information

1. Date of birth (MM/DD/YYYY): / /
2. Age: \_\_\_\_\_\_\_  years  months
3. Current residence: Country: \_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Ethnicity:  Hispanic or Latino  Not Hispanic or Latino
5. Race: White Asian American Indian/Alaska Native Black or African American Native Hawaiian/Other Pacific Islander
6. Sex:  Male Female

## Symptoms

1. In the past day, have you experienced any of the following symptoms?

| **Symptom** | **Symptom Present?** | **Duration (no. of days)** |
| --- | --- | --- |
| **Systemic** |  |  |
| Fever >100.4F (38C) | Yes No Unk |  |
| Subjective fever (felt feverish) | Yes No Unk |  |
| Cough (new onset or worsening of chronic cough) | Yes No Unk |  |
| Shortness of breath (dyspnea) | Yes No Unk |  |
| Vomiting | Yes No Unk |  |
| Nausea | Yes No Unk |  |
| Diarrhea (≥3 loose/looser than normal stools/24hr period) | Yes No Unk |  |

## Medical History

1. Do you have any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chronic Lung Disease | Yes | No | Unknown | Specify: |
| Smoking | Yes, current | Yes, former | No | Unknown |
| Active tuberculosis | Yes | No | Unknown |  |
| Diabetes Mellitus | Yes | No | Unknown | Specify: |
| Cardiovascular disease | Yes | No | Unknown | Specify: |
| Renal disease | Yes | No | Unknown | Specify: |
| Liver disease | Yes | No | Unknown | Specify: |
| Immunocompromised Condition | Yes | No | Unknown | Specify: |
| Neurologic/neurodevelopmental disorder | Yes | No | Unknown | Specify: |
| Other chronic diseases | Yes | No | Unknown | Specify: |

## Social History

1. Have you been to a shelter in the last 2 weeks (14 days) before your symptoms started or your test was positive? (Any of the symptoms listed above)

If yes, name of shelters where you have slept? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not in shelters, where have you slept? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where have you eaten your meals in the last 2 weeks (14 days) before your symptoms started or your test was positive?

Names of places you went to get your meals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been to any places in the last 2 weeks (14 days) to hang out or be with other people?

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

1. Did you receive any other services in the last 2 weeks (14 days) before your symptoms or your test was positive started? (Examples: Day shelters, shower/bathroom/lockers, case management, job placement/training)

Names of places\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you receive any medical services in the last 2 weeks (14 days) before your symptoms started or your test was positive? (Examples: mobile clinic, hospitals, ER, clinic)

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

1. Did you have a court date or stay in a correctional facility in the 2 weeks (14 days) before your symptoms started or your test was positive?

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

## Laboratory testing

27. If yes, what type of specimen was collected?

|  |  |
| --- | --- |
| **Specimen Type** | **ORIGINAL Specimen ID** |
| NP swab |  |
| OP swab |  |
| Nasal swab |  |

**This is the end of the case report form. Thank you very much for your time. If you have any questions please feel free to contact the CDC at 770-488-7100 or** [**eocreport@cdc.gov**](mailto:eocreport@cdc.gov)