



Human Infection with 2019 Novel Coronavirus (2019-nCoV) Homeless Study Follow-up Investigation Form

State: _____

Source Case state/local ID: _____

State/local health dept.: _____

Source Case CDC 2019-nCoV ID^b: _____

Contact ID^a: _____

Contact 2019-nCoV ID^c: _____

- a. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case 0023CA has contacts 0023CA-001 and 0023CA-002
- b. Complete with ID of the associated confirmed case who identified this contact
- c. 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 _____



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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

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

Symptom	Symptom Present?			Duration (no. of days)
Systemic				
Fever >100.4F (38C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Subjective fever (felt feverish)	<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	
Shortness of breath (dyspnea)	<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	
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Diarrhea (≥ 3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	

Medical History

8. Do you have any of the following:

Chronic Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Smoking	<input type="checkbox"/> Yes, current	<input type="checkbox"/> Yes, former	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Active tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Immunocompromised Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Neurologic/neurodevelopmental disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:
Other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Specify:



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

4. 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 _____
5. 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)

6. 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



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

Specimen Type	ORIGINAL Specimen ID
<input type="checkbox"/> NP swab	
<input type="checkbox"/> OP swab	
<input type="checkbox"/> 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 eoreport@cdc.gov