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?

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)	☐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