



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: _____ Other point of contact _____ Other point of contact Phone: Relationship to case patient: _____
Phone No. 2: _____ name: _____
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?

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		

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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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.

Chronic Lung Disease				
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) _____
Diabetes Mellitus				
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	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
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) _____
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

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			
		Positive	Negative	Indeterminate	Pending
NP Swab	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OP Swab	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sputum	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchoalveolar lavage (BAL) fluid	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheal fluid	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serum	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Other, specify _____	___/___/___ (MM/DD/YYYY)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
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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 <u>household members</u> , <u>friends</u> , <u>acquaintances</u> , or <u>co-workers</u> 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

Internal use

CDC nCoV ID _____

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

2019 novel coronavirus (2019-nCoV) patient under investigation (PUI) form

As soon as possible, notify and send completed form to: 1) your local/state health department, and 2) CDC: email (eocreport@cdc.gov, subject line: nCoV PUI Form) or fax (770-488-7107). If you have questions, contact the CDC Emergency Operations Center (EOC) at 770-488-7100.

Today's date _____ State patient ID _____ NNDSS local record ID/Case ID¹ _____ State _____ County _____

Interviewer's name _____ Phone _____ Email _____

Physician's name _____ Phone _____ Pager or Email _____

Sex M F Age _____ yr mo Residency US resident Non-US resident, country _____

PUI Criteria

Date of symptom onset _____

Does the patient have the following signs and symptoms (check all that apply)?

Fever² Cough Sore throat Shortness of breath

In the 14 days before symptom onset, did the patient:

Spend time in Wuhan City, China? Y N Unknown

Does the patient live in Wuhan City? Y N Unknown

Date traveled to Wuhan City _____ Date traveled from Wuhan City _____ Date arrived in US _____

Have close contact³ with a person who is under investigation for 2019-nCoV while that person was ill? Y N Unknown

Have close contact³ with a laboratory-confirmed 2019-nCoV case while that case was ill? Y N Unknown

Additional Patient Information

Is the patient a health care worker? Y N Unknown

Have history of being in a healthcare facility (as a patient, worker, or visitor) in Wuhan City, China? Y N Unknown

Is patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which nCoV is being evaluated? Y N Unknown

Does the patient have these additional signs and symptoms (check all that apply)?

Chills Headache Muscle aches Vomiting Abdominal pain Diarrhea Other, Specify _____

Diagnosis (select all that apply): Pneumonia (clinical or radiologic) Y N Acute respiratory distress syndrome Y N

Comorbid conditions (check all that apply): None Unknown Pregnancy Diabetes Cardiac disease Hypertension

Chronic pulmonary disease Chronic kidney disease Chronic liver disease Immunocompromised Other, specify _____

Is/was the patient: Hospitalized? Y, admit date _____ N Admitted to ICU? Y N

Intubated? Y N On ECMO? Y N Patient died? Y N

Does the patient have another diagnosis/etiology for their respiratory illness? Y, Specify _____ N Unknown

Respiratory diagnostic results

Test	Pos	Neg	Pending	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Test	Pos	Neg	Pending	Not done
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimens for 2019-nCoV testing

Specimen type	Specimen ID	Date collected	Sent to CDC?
NP swab			<input type="checkbox"/>
OP swab			<input type="checkbox"/>
Sputum			<input type="checkbox"/>
BAL fluid			<input type="checkbox"/>
Tracheal aspirate			<input type="checkbox"/>

Specimen type	Specimen ID	Date collected	Sent to CDC?
Stool			<input type="checkbox"/>
Urine			<input type="checkbox"/>
Serum			<input type="checkbox"/>
Other, specify _____			<input type="checkbox"/>
Other, specify _____			<input type="checkbox"/>

¹ For NNDSS reporters, use GenV2 or NETSS patient identifier.

² Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations

³ Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection); or b) having direct contact with infectious secretions

(e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

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.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/____/____

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....



Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: _____

Case state/local ID: _____

Reporting health department: _____

CDC 2019-nCoV ID: _____

Contact ID ^a: _____

NNDSS loc. rec. ID/Case ID ^b: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. ^bFor NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

<p>What is the current status of this person?</p> <input type="checkbox"/> PUI, testing pending <input type="checkbox"/> PUI, tested negative <input type="checkbox"/> Presumptive case (positive local test), confirmatory testing pending <input type="checkbox"/> Presumptive case (positive local test), confirmatory tested negative <input type="checkbox"/> Laboratory-confirmed case <input type="checkbox"/> Probable case	<p>Ethnicity:</p> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Not specified	<p>Date of first positive specimen collection (MM/DD/YYYY): ____/____/____</p> <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<p>Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, admission date 1 ____/____/____ (MM/DD/YYYY) If yes, discharge date 1 ____/____/____ (MM/DD/YYYY)</p> <p>Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days) _____</p> <p>Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Date of death (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown date of death</p>
<p>Report date of PUI to CDC (MM/DD/YYYY): ____/____/____</p> <p>Report date of case to CDC (MM/DD/YYYY): ____/____/____</p> <p>County of residence: _____</p> <p>State of residence: _____</p>	<p>Sex:</p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	<p>Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p> <p>Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p> <p>Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p> <p>Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No</p>	
<p>Race (check all that apply):</p> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____ <p>Date of birth (MM/DD/YYYY): ____/____/____</p> <p>Age: _____</p> <p>Age units(yr/mo/day): _____</p>			
<p>Symptoms present during course of illness:</p> <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown	<p>If symptomatic, onset date (MM/DD/YYYY): ____/____/____</p> <input type="checkbox"/> Unknown	<p>If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/____/____</p> <input type="checkbox"/> Still symptomatic <input type="checkbox"/> Unknown symptom status <input type="checkbox"/> Symptoms resolved, unknown date	

Is the patient a health care worker in the United States? Yes No Unknown

Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? Yes No Unknown

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Travel to Wuhan | <input type="checkbox"/> Community contact with another lab-confirmed COVID-19 case-patient | <input type="checkbox"/> Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology |
| <input type="checkbox"/> Travel to Hubei | <input type="checkbox"/> Any healthcare contact with another lab-confirmed COVID-19 case-patient | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Travel to mainland China | <input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Travel to other non-US country specify: _____ | <input type="checkbox"/> Animal exposure | |
| <input type="checkbox"/> Household contact with another lab-confirmed COVID-19 case-patient | | |

If the patient had contact with another COVID-19 case, was this person a U.S. case? Yes, nCoV ID of source case: _____ No Unknown N/A

Under what process was the PUI or case first identified? (check all that apply): Clinical evaluation leading to PUI determination

Contact tracing of case patient Routine surveillance EpiX notification of travelers; if checked, DGMQID _____

Unknown Other, specify: _____



CDC 2019-nCoV ID:

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form

Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): Patient interview Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?		
Fever >100.4F (38C) ^c	<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
Chills	<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
Runny nose (rhinorrhea)	<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
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
Nausea or vomiting	<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
Abdominal pain	<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
Other, specify: _____			

Pre-existing medical conditions?

Yes No Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<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	
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Immunocompromised Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Neurologic/neurodevelopmental/intellectual disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
If female, currently pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Current smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Former smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			<input type="checkbox"/>		<input type="checkbox"/>	
OP Swab			<input type="checkbox"/>		<input type="checkbox"/>	
Sputum			<input type="checkbox"/>		<input type="checkbox"/>	
Other, Specify: _____			<input type="checkbox"/>		<input type="checkbox"/>	

Additional State/local Specimen IDs: _____



Human Infection with 2019 Novel Coronavirus (nCoV) Household Contact Questionnaire V1.5 rev 3/24/2020 (Household Transmission Investigation)

State: WI

Household ID: WI-_____

Study ID: WI-_____

This questionnaire is to be administered to each household member (excluding the index patient).

Interview Information

1. Date of Interview: ___/___/___ (MM/DD/YYYY)
2. Name of Interviewer: _____
3. Person completing the interview: Self Parent/guardian: _____
 Other: _____

Household Member Information

4. Household member's name: First: _____ Last: _____
5. Date of birth: ___/___/___ (MM/DD/YYYY)
6. Age: _____ years months days
7. Ethnicity: Hispanic/Latino Non-Hispanic/Latino Not Specified
8. Race: White Black Asian
 Am Indian/Alaska Nat Nat Hawaiian/Other PI Other, specify: _____ Unknown
9. Sex: Male Female
10. What is your relationship to [insert name of index patient]?
 Spouse Child Parent Grandparent Sibling Employee Other _____
11. What is the highest level of education you have completed?
 Less than high school
 High school diploma/GED
 Some college credit, no degree
 Technical degree/Associate's degree
 Bachelor's degree (i.e., B.A., B.S.)
 Master's degree (i.e., MBA)
 Doctorate or professional degree
12. What is your occupation? _____

SARS-CoV-2 testing for household contacts

13. Have you been tested for coronavirus? Yes No
If yes, please complete the following information:
 - a. Date of specimen collection _____ (MM/DD/YYYY)
 - b. Result of test: Positive Negative Pending Don't know/other _____
 - c. Date of test result _____ (MM/DD/YYYY)
 - d. Were you experiencing symptoms when you were tested? Yes No
 - i. Describe: _____
 - e. Date of symptom onset: _____ (MM/DD/YYYY)

Notes: _____

Past Medical History

14. Please provide pre-existing medical conditions (complete regardless of age):



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State: WI

Household ID: WI-_____

Study ID: WI-_____

Asthma/reactive airway disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Active tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, on treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Any other chronic lung diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hypertension (high blood pressure)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Coronary artery disease/heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Any other heart diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Any kidney disorders? If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
End-stage renal disease/dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Renal insufficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other kidney diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Any liver disorders? If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Alcoholic liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cirrhosis/End stage liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other chronic liver diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
HIV infection. If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
AIDS or CD4 count currently <200	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Ever receive a transplant? If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Solid organ transplant				If YES, date: _____
Stem cell transplant (e.g., bone marrow transplant)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, date: _____
Cancer: current/in treatment or diagnosed in last 12 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Immunosuppressive therapy/medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____ For what condition: _____
Other immunosuppressive conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Any other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Developmental or neurologic disorder. If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____



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State: WI

Household ID: WI-_____

Study ID: WI-_____

Chromosomal or genetic abnormality	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Cerebral palsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Any other development or neurologic Disorder				If YES, specify: _____
Any other medical conditions as a child	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Were you born premature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, gestation at birth: _____ wks

15. [If female] Are you currently pregnant? Yes No Unknown N/A
16. [If female] Are you postpartum (≤6 weeks postpartum)? Yes No Unknown N/A
17. [If female] Are you breastfeeding? Yes No Unknown N/A
18. [If child <3 years] Is your child being breastfed? Yes No Unknown N/A

Smoking/Vaping

19. Do you currently smoke tobacco on a daily basis, less than daily, or not at all?
 Daily Less than daily Not at all Unknown
20. [If not a daily smoker] In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?
 Daily Less than daily Not at all Unknown
21. Do you currently vape or use electronic cigarettes on a daily basis, less than daily, or not at all?
 Daily Less than daily Not at all Unknown

Symptoms Prior to Index Case's Onset

Note to interviewer: record symptom onset date of the index patient from household questionnaire cover sheet. Ask the interviewee to get a calendar or personal diary. ___/___/___ (MM/DD/YYYY)

22. Did you experience any symptoms of a respiratory illness in the **2 weeks prior** to [insert name of index patient] becoming ill?
 Yes No Unknown

Exposures Outside of the Household

Note to interviewer: remind the interviewee to consult a calendar or diary for the following questions.

Date of index patient symptom onset: ___/___/___ (MM/DD/YYYY)

14 days prior to index patient's symptom onset: ___/___/___ (MM/DD/YYYY)

23. **Since [14 days PRIOR to the index patient's symptom onset]...**

Exposure	Answer
...have you traveled (internationally or within the U.S., or on a cruise)?	<input type="checkbox"/> Yes: with index patient <input type="checkbox"/> Yes: w/o index patient <input type="checkbox"/> No <input type="checkbox"/> Unknown
...attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other events)?	<input type="checkbox"/> Yes: with index patient <input type="checkbox"/> Yes: w/o index patient <input type="checkbox"/> No <input type="checkbox"/> Unknown



Human Infection with 2019 Novel Coronavirus (nCoV) Household Contact Questionnaire V1.5 rev 3/24/2020 (Household Transmission Investigation)

State: WI

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Study ID: WI- _____

...have close contact (e.g. caring for, speaking with, touching, physically within 6 feet) with any suspected or known COVID-19 case outside of the household?	<input type="checkbox"/> Yes: with index patient <input type="checkbox"/> Yes: w/o index patient <input type="checkbox"/> No <input type="checkbox"/> Unknown
...work in a healthcare setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what types of healthcare settings: <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Dental Clinic <input type="checkbox"/> Dialysis Center <input type="checkbox"/> ICU <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Other, specify: _____ What type of job do you have at the healthcare setting? <input type="checkbox"/> Admin staff <input type="checkbox"/> Nurse/Nurse tech <input type="checkbox"/> Doctor <input type="checkbox"/> EMS <input type="checkbox"/> Other, specify: _____
...visit a healthcare setting (e.g. visit someone or have an appointment -- at a hospital, ED, outpatient clinic, dental clinic, long-term care facility)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...attend/work at a daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...attend/work at a school?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Symptoms After the Index Case's Onset

Note to interviewer: record symptom onset date of the index patient from household questionnaire. Ask the interviewee to get a calendar or personal diary. ___/___/___ (MM/DD/YYYY)

24. Since ___/___/___, when [the index case] first became symptomatic, have you experienced any of the following symptoms?	Symptom Present?
Fever >100.4F (38C) ^c	<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
Chills	<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
Runny nose (rhinorrhea)	<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
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk



Human Infection with 2019 Novel Coronavirus (nCoV) Household Contact Questionnaire V1.5 rev 3/24/2020 (Household Transmission Investigation)

State: WI

Household ID: WI- _____

Study ID: WI- _____

Shortness of breath (dyspnea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Nausea/Vomiting	<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
Abdominal pain	<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
Other, specify:			

25. What date did you **first** become symptomatic?
 ____ / ____ / ____ (MM/DD/YYYY)

26. Are you currently experiencing any symptoms of a respiratory illness, such as fever, cough, or shortness of breath?
 (Note: Flag any symptomatic household members for workflow planning and offer of self-nasal swab during visit)
 Yes No Unknown

Exposures to the Index Patient

Note to interviewer: record symptom onset date of the index patient from household questionnaire. Ask the interviewee to get a calendar or personal diary. ____/____/____ (MM/DD/YYYY)

27. Since [index case]'s symptoms started on [date of symptom onset of the index patient], did you

Exposure	Answer
...spend more than 10 minutes within 6 feet of the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...have face to face contact with the index patient (i.e., within about 2 feet)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...spend any time within 6 feet of the index patient while he/she was coughing or sneezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...shake hands with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...hug the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...kiss the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...take an object handed from or handled by the index patient? (e.g., pen, paper, food, utensil, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...sleep in the same bedroom as the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...sleep in the same bed as the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...share a bathroom with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...prepare food with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...share meals with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...eat from the same plate as the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown



Human Infection with 2019 Novel Coronavirus (nCoV) Household Contact Questionnaire V1.5 rev 3/24/2020 (Household Transmission Investigation)

State: WI

Household ID: WI- _____

Study ID: WI- _____

Exposure	Answer
...share a utensil with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...share a drinking cup/glass with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...travel in the same vehicle (car, bus, airplane), sitting within 6 feet of the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

28. Did you serve as primary caretaker for the index patient while he/she was ill? Yes No Unknown

29. When was your last exposure (*include any exposures described above*) to [*name of the index patient*]?
 ____/____/____ (MM/DD/YYYY) Ongoing exposure

30. How many days have you spent in the household since [*date of symptom onset of index patient*]? _____

31. How many nights have you spent in the household since [*date of symptom onset of index patient*]? _____



Human Infection with 2019 Novel Coronavirus (nCoV) Household Questionnaire V1.4 rev 3/23/2020 (Household Transmission Investigation)

State: ___WI_____

Household ID: __WI-_____

HOUSEHOLD QUESTIONNAIRE COVER SHEET

- If there are multiple confirmed COVID-19 cases in the household at baseline, identify the case with the earliest symptom onset as the index patient.

Index case information (fill out ahead of time from PUI/CRF and verify at time of questionnaire administration)

1. Index patient's name: First: _____ Last: _____
2. Phone number: _____
3. Address: _____
4. Index patient's study ID: _____
5. Index patient's date of birth: ____/____/____ (MM/DD/YYYY)
6. Date of symptom onset of the index patient: ____/____/____ (MM/DD/YYYY)
7. Date of specimen collection of index patient (first positive test): ____/____/____ (MM/DD/YYYY)
8. Date index patient received test result: ____/____/____ (MM/DD/YYYY)

Household member(s) (fill out ahead of time and verify/complete at time of questionnaire)

Name (first last)	Study ID	Relationship to case	Age (yrs)	Sex	DOB	Phone number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						



Human Infection with 2019 Novel Coronavirus (nCoV) Household Questionnaire V1.4 rev 3/23/2020 (Household Transmission Investigation)

State: ___WI___

Household ID: __WI-_____

HOUSEHOLD QUESTIONNAIRE

Note: This questionnaire is to be administered to each household at enrollment. If possible, the head of household should provide information for questionnaire.

Interview information

1. Date of Interview: MM / DD / YYYY
2. Name of Interviewer: _____
3. Name of household member providing information for interview: _____
Head of household? Yes No If no, relationship to head of household: _____
4. Location of the interview:
 At the household
 Over the phone
 Other, specify: _____

Describing the household

5. Location of the household:
County: _____ State: _____ ZIP Code: _____
6. Confirm the number of household members from the cover sheet: _____ persons
Note to interviewer: Include resident family members, live-in staff, and long-term visitors.
7. What is the highest level of education completed by the head of the household?
 Less than high school
 High school diploma/GED
 Some college credit, no degree
 Technical degree/Associate's degree
 Bachelor's degree (i.e., B.A., B.S.)
 Master's degree (i.e., MBA)
 Doctorate or professional degree
8. What is the occupation of the head of the household? _____
9. Do you live in a single-family home or multi-unit housing (like an apartment)?
 Single-family home Multi-unit housing Other (specify): _____
10. Do you own or rent your home? Own Rent
11. What is the approximate size of the residence: _____ square feet
12. Number of floors in the residence: _____
13. Number of bedrooms in the residence: _____
14. Number of bathrooms in the residence: _____
15. What type of heating does this residence have?
 Forced air Radiator Other, specify: _____ Don't know



Human Infection with 2019 Novel Coronavirus (nCoV) Household Questionnaire V1.4 rev 3/23/2020 (Household Transmission Investigation)

State: WI

Household ID: WI-

16. Since the index patient developed symptoms on *[insert date of symptom onset]*:
- Has air conditioning been used?
 Yes No
 - Has the household opened windows for ventilation?
 Yes No
 - Has any other form of ventilation (e.g. ceiling fans or portable fans) been used?
 Yes No

Index patient information

Note to interviewer: if the household member completing the interview is not the index patient, ask if the index patient is available for several questions.

17. Are you still experiencing symptoms related to your COVID-19 illness?

Yes No Never had symptoms

If no, what date were you back to normal health? MM / DD / YYYY

18. Since you developed respiratory illness, have you done any of the following at home? (*select all that apply*)

- | | |
|---|----------------------|
| <input type="checkbox"/> Slept alone in a bed | If yes, dates: _____ |
| <input type="checkbox"/> Slept alone in separate bedroom | If yes, dates: _____ |
| <input type="checkbox"/> Used a private bathroom (not shared) | If yes, dates: _____ |
| <input type="checkbox"/> Wore personal protective equipment | If yes, dates: _____ |
| <input type="checkbox"/> Mask <input type="checkbox"/> Gloves <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Other: _____ | If yes, dates: _____ |

19. Which household member has been assisting you as your primary caretaker during your illness?

Name: _____ None Unknown

20. What tasks has this primary caretaker assisted you with?

- Taking temperature Serving meals Cleaning bedroom Cleaning bathroom Help with toileting
 Other, specify _____

Other:

21. Does the household have pets? Yes No

If yes, how many? _____ pets

Note to the interviewer: only include mammalian pets (no livestock).

Species (dog, cat)	Age (yrs)	Indoor Pet? (y/n)	Signs of illness? (y/n)	If ill, date of illness onset
1.				
2.				
3.				
4.				

Notes:

Day of follow-up: 0/14 (Date of specimen collection)

Date (MM/DD/YYYY): _____

Name (First Last): _____

Household ID: WI-_____

HH member ID: WI-_____

Household Member Symptom Diary

1. Who is providing this information today?
 Self Parent/guardian
 Other, specify name: _____; relationship: _____
2. What is the current time? _____ AM PM
3. Did you sleep in the household last night? Yes No
4. During the past 24 hours, have you experienced any of the following symptoms?

Symptom	Experienced in the past 24 hours?
Documented Fever $\geq 100.4F$ (38C) Highest temp _____ F	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fatigue (tired)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cough (new onset or worsening of chronic cough) <input type="checkbox"/> Dry <input type="checkbox"/> Productive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Discomfort/burning while breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diarrhea (≥ 3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Who should we contact for your daily reminder? Me Other family member _____

Preferred method of contact: Phone call Text Email

Phone/email: _____

**Human Infection with SARS-CoV-2
Household Animal Questionnaire**

*This questionnaire is to be completed by primary caretaker **for each pet/companion animal** in the household.*

State/local ID: _____
 Household ID: _____
 Pet/Animal ID: _____

Date interview completed: / / (MM/DD/YYYY)
 Interviewer Name: _____ State/Local Health Department _____
 Who is providing information for this form?
 Index COVID-19 patient
 Other, specify name: _____ Relationship to index patient: _____
 How many pets/companion animals belong to the household? _____ (Include service animals and any animals that primarily live outside if the household members consider them "pets" and interact with them regularly.)

1. Pet Name: _____ Pet ID (e.g. 01, 02, 03...): _____
 a. Primary Caretaker of [PET NAME]: _____
 b. Animal Type: Dog Cat Other (please describe) _____
 a. Breed _____
 c. Age of Pet (years/months): _____ years or months (Circle one)
 d. Sex of Pet: Male Female
 a. Has [PET NAME] been spayed/neutered: Yes No

2. Does [PET NAME] have any current health conditions? Yes No
 a. If yes, please describe these health conditions or illnesses including when they started:

Condition	Date Started	Medications or supplement for the condition

b. Please describe any other medications or supplements that [PET NAME] takes.

3. On a regular day before [COVID-19 CASE] began home isolation, how long per day and what types of interaction (e.g., walking, grooming, petting, cuddling) did [COVID-19 CASE] usually have with [PET NAME]?
 a. Duration of interaction with pet per day:
 <1 hour 1-3 hours 4-6 hours 7-9 hours 10-12 hours 12+ hours
 b. Types of interaction/contact with pet (mark all that apply):
 Taking for walks Petting Sharing food
 Grooming Cuddling Letting the pet lick their face or hands
 Feeding Sleeping in the same location Other (please describe): _____

4. On a regular day since [COVID-19 case] started home isolation, how long per day and what types of interaction has [COVID-19 CASE] had with [PET NAME]?
 a. Duration of interaction with pet per day:
 <1 hour 1-3 hours 4-6 hours 7-9 hours 10-12 hours 12+ hours
 b. Types of interaction/contact with pet (mark all that apply):
 Taking for walks Petting Sharing food
 Grooming Cuddling Letting the pet lick their face or hands
 Feeding Sleeping in the same location Other (please describe): _____
 c. Was [COVID-19 CASE] wearing any personal protective equipment (e.g. gloves or a cloth face covering)?
 Yes No
 a. If yes, please describe: _____

<p>5. Is your pet: <input type="checkbox"/> Primarily indoors, <input type="checkbox"/> outdoors or <input type="checkbox"/> both?</p> <p>a. If both, what percent of time is spent indoors? _____%</p> <p>b. Is [PET NAME] allowed anywhere in the house or restricted to certain areas? _____</p> <p>c. If restricted, specify where: _____</p>								
<p>6. On a regular day since [COVID-19 case] started home isolation, where does [PET NAME] go outside of the home (mark all that apply)?</p> <table> <tr> <td><input type="checkbox"/> On leash walks at park</td> <td><input type="checkbox"/> Dog park</td> </tr> <tr> <td><input type="checkbox"/> Free roaming in neighborhood/on property</td> <td><input type="checkbox"/> Doggy Daycare</td> </tr> <tr> <td><input type="checkbox"/> On leash walks in neighborhood/on property</td> <td><input type="checkbox"/> Service function (e.g. therapy dog)</td> </tr> <tr> <td><input type="checkbox"/> Indoors only</td> <td><input type="checkbox"/> Other (please describe): _____</td> </tr> </table>	<input type="checkbox"/> On leash walks at park	<input type="checkbox"/> Dog park	<input type="checkbox"/> Free roaming in neighborhood/on property	<input type="checkbox"/> Doggy Daycare	<input type="checkbox"/> On leash walks in neighborhood/on property	<input type="checkbox"/> Service function (e.g. therapy dog)	<input type="checkbox"/> Indoors only	<input type="checkbox"/> Other (please describe): _____
<input type="checkbox"/> On leash walks at park	<input type="checkbox"/> Dog park							
<input type="checkbox"/> Free roaming in neighborhood/on property	<input type="checkbox"/> Doggy Daycare							
<input type="checkbox"/> On leash walks in neighborhood/on property	<input type="checkbox"/> Service function (e.g. therapy dog)							
<input type="checkbox"/> Indoors only	<input type="checkbox"/> Other (please describe): _____							
<p>7. Since [COVID-19 case] was diagnosed, has this pet developed any new health condition (mark all that apply)?</p> <table> <tr> <td><input type="checkbox"/> Coughing</td> <td><input type="checkbox"/> Runny nose</td> </tr> <tr> <td><input type="checkbox"/> Sneezing</td> <td><input type="checkbox"/> Vomiting</td> </tr> <tr> <td><input type="checkbox"/> Difficulty breathing or shortness of breath</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Lethargy</td> <td><input type="checkbox"/> Other (please describe): _____</td> </tr> </table>	<input type="checkbox"/> Coughing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty breathing or shortness of breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Other (please describe): _____
<input type="checkbox"/> Coughing	<input type="checkbox"/> Runny nose							
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Vomiting							
<input type="checkbox"/> Difficulty breathing or shortness of breath	<input type="checkbox"/> Diarrhea							
<input type="checkbox"/> Lethargy	<input type="checkbox"/> Other (please describe): _____							
<p>8. Have you/the patient heard or read about the CDC guidelines about a person who is sick restricting contact with pets in the house? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>9. Is there any additional information you think we should know about [PET NAME]?</p> <p>a. If Yes: _____</p>								
<p>10. Are there small pets in the household, such as rats, mice, hamsters, gerbils, rabbits, or guinea pigs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. If Yes, please list the type of animal(s) and their name(s): _____</p> <p>b. If No → Thank you for your time and participation.</p>								



Human Infection with 2019 Novel Coronavirus (nCoV) Household Close-Out Form V1.1 4/6/2020 (Household Transmission Investigation)

State: ___WI___
Household ID: __WI-_____

HOUSEHOLD CLOSE-OUT FORM

Please fill out this form when scheduling the final household visit.

1. Date of questionnaire: ___/___/_____
2. Date of final household visit (i.e., last serum collection): ___/___/_____
3. Is there extended symptom monitoring for confirmed cases beyond the final household visit? Yes No
If yes, please provide approximate end date of symptom monitoring for this household: ___/___/_____
4. Have you changed anything in your household behaviors to prevent spread in the family? *Check all that are mentioned and DO NOT read the choices. Only include behaviors/interventions since time of enrollment:*
 - Ill person/people (or persons diagnosed with COVID-19) wore a mask in the home
 - My family is wearing masks, regardless of symptoms
 - Ill person/people (or persons diagnosed with COVID-19) slept in a different room
 - Ill person/people (or persons diagnosed with COVID-19) used a separate bathroom
 - Ill person/people (or persons diagnosed with COVID-19) eat separately
 - Ill person/people (or persons diagnosed with COVID-19) moved out of the house
 - Used bleach wipes on high touch surfaces
 - Used Lysol/cleaning spray on high touch surfaces
 - Used Lysol/cleaning spray frequently in the bathroom
 - Used Lysol/cleaning spray on high touch surfaces
 - My family is washing hands frequently.
 - My family stopped sharing plates/utensils/cups/food.
 - My family increased the use of fans/open windows to increase air flow.
 - My family stopped sharing common items like towels.
 - My family is wearing gloves in the home.
 - Other: specify _____



Human Infection with 2019 Novel Coronavirus (nCoV) Household Close-Out Form V1.1 4/6/2020 (Household Transmission Investigation)

State: WI
Household ID: WI-

If a family member mentions wearing masks, ask questions 5-6:

5. What type of masks were worn (*check all that apply*):

- Cloth
- Medical/Surgical
- N-95
- Other, non-traditional mask (e.g., scarves, other barriers, etc.): specify _____

6. If there is more than 1 ill person (or persons diagnosed with COVID-19) in the household, did all ill people wear a mask? Yes No Not applicable

7. Did any household pets become sick during the follow-up period? Yes No Not applicable

If yes, describe symptoms and duration: _____

8. Please provide details for each household member in the table below:

Name	Study ID	Hospitalized due to COVID-19	If confirmed by PCR, provide preliminary determination of primary vs. secondary cases*	Withdrawal?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Primary case <input type="checkbox"/> Secondary case if secondary, suspected outside infection? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain: _____ _____ _____ <input type="checkbox"/> N/A	Withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No If withdraw, date of withdrawal: ____/____/_____ Reasons: <input type="checkbox"/> hospitalized, alive <input type="checkbox"/> deceased <input type="checkbox"/> moved <input type="checkbox"/> declined <input type="checkbox"/> other _____



Human Infection with 2019 Novel Coronavirus (nCoV) Household Close-Out Form V1.1 4/6/2020 (Household Transmission Investigation)

State: WI

Household ID: WI-

Name	Study ID	Hospitalized due to COVID-19	If confirmed by PCR, provide preliminary determination of primary vs. secondary cases*	Withdrawal?
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Primary case <input type="checkbox"/> Secondary case if secondary, suspected outside infection? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain: _____ _____ _____ <input type="checkbox"/> N/A	Withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No If withdraw, date of withdrawal: ____/____/____ Reasons: <input type="checkbox"/> hospitalized, alive <input type="checkbox"/> deceased <input type="checkbox"/> moved <input type="checkbox"/> declined <input type="checkbox"/> other _____
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Primary case <input type="checkbox"/> Secondary case if secondary, suspected outside infection? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain: _____ _____ _____ <input type="checkbox"/> N/A	Withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No If withdraw, date of withdrawal: ____/____/____ Reasons: <input type="checkbox"/> hospitalized, alive <input type="checkbox"/> deceased <input type="checkbox"/> moved <input type="checkbox"/> declined <input type="checkbox"/> other _____
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Primary case <input type="checkbox"/> Secondary case if secondary, suspected outside infection? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain: _____ _____ _____ <input type="checkbox"/> N/A	Withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No If withdraw, date of withdrawal: ____/____/____ Reasons: <input type="checkbox"/> hospitalized, alive <input type="checkbox"/> deceased <input type="checkbox"/> moved <input type="checkbox"/> declined <input type="checkbox"/> other _____



Human Infection with 2019 Novel Coronavirus (nCoV) Household Close-Out Form V1.1 4/6/2020 (Household Transmission Investigation)

State: WI

Household ID: WI-

Name	Study ID	Hospitalized due to COVID-19	If confirmed by PCR, provide preliminary determination of primary vs. secondary cases*	Withdrawal?
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Primary case <input type="checkbox"/> Secondary case if secondary, suspected outside infection? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain: _____ _____ _____ <input type="checkbox"/> N/A	Withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No If withdraw, date of withdrawal: ____/____/_____ Reasons: <input type="checkbox"/> hospitalized, alive <input type="checkbox"/> deceased <input type="checkbox"/> moved <input type="checkbox"/> declined <input type="checkbox"/> other _____
*The determination can be made at the time the patient is confirmed to be positive (i.e., at baseline, an interim visit, or day 14)				

Notes for field investigators:

- Primary case/s
 - o Primary case is the confirmed COVID-19 case with the earliest symptom onset in the household. Oftentimes, this will be the index patient.
 - o If there are multiple household cases who have the earliest symptom onset (within a day; or, not within a day but they have a known common exposure), we will consider them as co-primary cases who introduced the virus into the household. Please check them as primary cases in the table.
- Secondary cases
 - o Ideally, we'd like to identify secondary cases as household members who are subsequently infected by the primary case/s.
 - o However, in practice, we may not be able to differentiate secondary vs. tertiary (or further generations of) transmission, or infections due to exposure outside of the household
 - o Thus, for now, we plan to **consider all subsequent infections in the household as secondary cases**, and estimate the overall risk of infection (i.e., % household members subsequently infected) as a proxy for household secondary attack rate
 - This approach assumes that all subsequent infections in the household are due to exposures to the primary case/s
 - As the above assumption may be violated, please mark household cases with suspected/known infection due to outside sources as; as a sensitivity analysis, we will consider excluding them when estimating the secondary attack rate