Form Approved
OMB Control No.:0920-1305
Expiration date: xx/xx/xxxx

QID:_____

Chronic Q Fever - Enhanced Surveillance Follow-up Instrument

Survey instrument for clinician follow-up at 6, 12, 18, and 24 months after initial consultation request.

1. Date of follow-up: __/__/____ (DD/MM/YYYY)

2. Is the patient still serologically monitored for Q fever? ☐Yes ☐No ☐Unknown (*if yes go to 2a if no/unknown skip to 2b).*
    a. How frequently are Q fever serologies collected from the patient? Approximately every _____ months
    b. What was the date of the most recent titer values collected? __/__/___ (DD/MM/YYYY)
        i. What were these titers? Ph1 IgG _____; Ph2 IgG _____
    c. Were other titers collected? ☐Yes ☐No ☐Unknown (If yes, go to 2ci, if no/unknown, go to 3.)
        i. What was the date that these titers were collected? __/__/____ (DD/MM/YYYY)
        ii. What were these titers? Ph1 IgG _____; Ph2 IgG _____
    d. Were other titers collected? ☐Yes ☐No ☐Unknown (If yes, go to 2di, if no/unknown, go to 3.)
        i. What was the date that these titers were collected? __/__/____ (DD/MM/YYYY)
        ii. What were these titers? Ph1 IgG _____; Ph2 IgG _____

3. Has the patient had a PCR test since the last follow-up? ☐Yes ☐No ☐Unknown (*if yes go to 3a if no/unknown skip to 4).*
    a. What was the date of the most recent PCR test? __/__/___ (DD/MM/YYYY)
        i. What were the result? ☐Detected ☐Not Detected ☐Unknown

4. Has the patient completed antibiotic therapy? ☐Yes ☐No ☐Unknown (*if yes/no go to 3a, if unknown go to 4).*
    a. Which antibiotics did the patient receive? ☐Doxycycline ☐Hydroxychloroquine ☐Other _____
    b. How long has the patient on antibiotic therapy? _____(months)
    c. What was the dose and interval of these medications? _____ (dose, interval)
    d. Was the patient taken off any antibiotic during treatment due to side effects? ☐Yes ☐No ☐Unknown (*If 'no' or 'unknown', skip to question 2e*)
    e. *If yes which medication (s) were stopped?* ☐Doxycycline ☐Hydroxychloroquine ☐Other _____
    f. *What were the side effects?* ☐nausea ☐vomiting ☐fatigue ☐photosensitivity ☐ Other:_____ ☐ Unknown
    g. Did the patient develop any of the following complications from antibiotic therapy (select all that apply)?
        ☐ Retinal damage ☐QT prolongation ☐irreversible skin pigmentation

☐Other _____ ☐ None

5. Have the patient's symptoms changed since the initial consult?
   - ☐ Yes, symptoms have fully resolved *(go to question 5)*
   - ☐ Yes, symptoms improved but persist *(go to question 5)*
   - ☐ Yes, symptoms have worsened *(go to question 5)*
   - ☐ No *(go to question 6)*

6. Please describe any new or worsening symptoms: _____ (free text)

7. Did the patient die from complications of chronic Q fever? ☐Yes ☐No ☐Unknown (*If 'no' or 'unknown', go to question 7*.)
   a. Date of death: __/__/____ (DD/MM/YYYY)
   b. Cause of death per death certificate: _____(free text)

8. Was the patient hospitalized from complications of chronic Q fever? ☐Yes ☐No ☐Unknown (*If 'no' or 'unknown', go to question 8*.)
   a. Date of hospitalization: __/__/____ (DD/MM/YYYY)
   b. Duration of hospitalization: _____ (days)
   c. Cause of hospitalization and brief summary of hospital course: _____ (free text)

9. Was the patient diagnosed with lymphoma since the last consult? ☐Yes ☐No ☐Unknown
   a. If yes, please describe: _____ (free text)

10. Did the patient become pregnant since the last consult? ☐Yes ☐No ☐Unknown *If 'no' or 'unknown', go to question 17*.)

11. What treatment was provided during the patient's pregnancy? _____ (free text)

12. What was the outcome of the patient's pregnancy?
    - ☐ Term delivery *(go to question 13)*
    - ☐ Preterm delivery *(go to question 13)*
    - ☐ Currently pregnant *(go to question 15)*
    - ☐ Stillbirth
    - ☐ Miscarriage
    - ☐ Other loss of pregnancy

13. Were there any complications during delivery? ☐Yes ☐No ☐Unknown
    a. If yes, please describe: _____ free text

14. Were there any complications after delivery for the baby or patient? ☐Yes ☐No ☐Unknown
    a. If yes, please describe: _____ free text

15. Were there any complications during pregnancy? ☐Yes ☐No ☐Unknown
    a. If yes, please describe: _____ free text

16. Were any of the following studies performed? Choose all that apply:
    - ☐ Echocardiogram *(go to question 9)*

☐ MRI *(go to question 10)*
☐ CT Scan *(go to question 11)*
☐ PET Scan *(go to question 12)*

17. Details of echocardiography:
    a. What was the date of the exam: __/__/____ (DD/MM/YYYY)
    b. Was the exam transthoracic or transesophageal?
       ☐ Transthoracic
       ☐ Transesophageal
    c. Please provide a brief summary of findings: _____ (free text)

18. Details of MRI:
    a. What was the date of the exam: __/__/____ (DD/MM/YYYY)
    b. What was the anatomic location of the scan: _____ (free text)
    c. Please provide a brief summary of findings: _____ (free text)

19. Details of CT Scan:
    a. What was the date of the exam: __/__/____ (DD/MM/YYYY)
    b. What was the anatomic location of the scan: _____ (free text)
    c. Please provide a brief summary of findings: _____ (free text)

20. Details of PET Scan:
    a. What was the date of the exam: __/__/____ (DD/MM/YYYY)
    b. What was the anatomic location of the scan: _____ (free text)
    c. Please provide a brief summary of findings: _____ (free text)