

QID: _____

Chronic Q Fever – Enhanced Surveillance

ENROLLMENT/FIRST FORM

1. When was this patient first diagnosed with chronic Q fever? _____ (mm/yyyy)
2. Patient's date of birth _____ (mm/dd/yyyy)
3. Sex of patient: Male Female Transgender Non-binary Something Else Not specified
4. State of residence _____
5. Race: White Black American Indian/Alaska Native Asian Pacific Islander Not specified
6. Hispanic ethnicity: Yes No Unknown

Acute Q Fever History:

7. Was this patient previously diagnosed with acute Q fever? Yes No Unknown
(If 'no' or 'unknown', skip to question 8)
 - a. Date of acute Q fever diagnosis: _____ (mm/dd/yyyy) or Date Unknown
 - b. How was initial diagnosis made?
PCR Paired Serology Single serology Other _____ Unknown
 - c. Was the patient treated for acute Q fever? Yes No Unknown
 - i. If yes, what medication(s) were/was used and for what duration _____
 - d. Was treatment completed? Yes No Unknown

8. For female patients: was this patient pregnant at the time of acute Q fever diagnosis?
Yes No Unknown NA
(If 'no' or 'unknown', skip to question 9)
 - a. In which trimester did the symptoms begin (if unknown use diagnosis): 1st (weeks 1-12)
 2nd (weeks 13-28) 3rd (weeks 29-42) Unknown
 - b. Was the patient treated during pregnancy? Yes No Unknown *(If 'no' or 'unknown', skip to question 8f)*
 - c. At what week gestation did treatment begin? _____ weeks
 - d. When was treatment discontinued? _____ weeks or Still receiving treatment
 - e. Was treatment completed? Yes No Unknown
 - f. What antibiotics were used? Trimethoprim/sulfamethoxazole Other _____
Unknown
 - g. What was the duration of treatment? _____ weeks
 - h. Did this patient develop placentitis? Yes No Unknown
 - i. Did the patient develop any of the following complications of pregnancy *(select all that apply)*:
intrauterine growth restriction (IUGR) stillbirth miscarriage
premature delivery Other → Please specify other complications:

- j. Where any of the following newborn complications present?
 malformations (specify type: _____) hyperbilirubinemia kernicterus
 Other → Please specify other complications: _____
- k. What was the gestational age at birth? _____ weeks Unknown
- l. What was the weight at birth? _____ lbs. _____ ozs. Unknown

Risk Factors:

9. Did this patient have a history of any of the following cardiovascular conditions? (check all that apply):

- Rheumatic heart disease
 Aortic valve stenosis
 Aortic valve prolapse
 Aortic valve regurgitation
 Mitral valve stenosis
 Mitral valve prolapse
 Mitral valve regurgitation
 Pulmonic valve stenosis
 Pulmonic valve prolapse
 Pulmonic valve regurgitation
 Tricuspid valve stenosis
 Tricuspid valve prolapse
 Tricuspid valve regurgitation
 Prosthetic valve
 → Which valve was replaced? (check all that apply)
 Aortic Mitral Pulmonic Tricuspid
 → Date of most recent replacement: _____ (mm/dd/yyyy)
 → What type of valve replacement did the patient receive?
 Manufactured mechanical valve Human Donor valve Bioprosthetic-bovine
 Bioprosthetic-porcine
 → History of >1 valve replacement Yes No Unknown
- Aneurysm
 Vascular graft/stent
 Atrial septal defect
 Patent ductus arteriosus
 Ventricular septal defect
 Tetralogy of Fallot
 Other congenital heart defect → Please specify: _____
 Other heart valve problem → Please specify: _____

Clinical Findings:

10. What clinical signs and symptoms has the patient exhibited during the course of their illness? *Select all that apply.*

- relapsing fever chills weight loss night sweats fatigue Shortness of breath
 hepatosplenomegaly Other _____

11. Did this patient have culture negative endocarditis? Yes No Unknown

(If 'no' or 'unknown', skip to question 12)

- a. Please specify affected valve(s) (Check all that apply):
 - Aortic valve
 - Mitral valve
 - Pulmonary valve
 - Tricuspid valve
 - Unknown or None
- b. What imaging technologies were used to diagnose endocarditis (check all that apply)?
 - Transthoracic echocardiogram
 - Transesophageal echocardiogram
 - PET Scan
 - CT Scan
 - MRI
 - Other _____
- c. Was infected valve removed? Yes No Unknown
(If 'no' or 'unknown', skip to question 12)
- d. If yes, specify date of removal: _____ (mm/dd/yyyy)
- e. If removed, was the valve tested for presence of *Coxiella burnetii*? Yes No
 Unknown
(If 'no' or 'unknown', skip to question 12)
- f. Testing method: PCR IHC Culture Next-generation sequencing
 Unknown
- g. Results: Positive Negative Results not available

12. Did this patient have a vascular infection (i.e. infection of vascular graft, stent, or aneurysm) caused by *Coxiella burnetii*?

Yes No Unknown

(If 'no' or 'unknown', skip to question 13)

- a. If yes, please specify which type of vascular infection
 - vascular graft
 - stent
 - aneurysm
 - other _____
- b. Please specify location of infection: abdominal aorta thoracic aorta other _____
- c. Specify date of graft/stent placement: _____ (mm/dd/yyyy) NA
- d. Was infected graft/stent removed or aneurysm repaired? Yes No Unknown
(If 'no' or 'unknown', skip to question 12f)
- e. If yes, specify date of removal or repair: _____ (mm/dd/yyyy)
- f. Was the vascular infection tested for presence of *Coxiella burnetii*? Yes No
 Unknown
(If 'no' or 'unknown', skip to question 13)
- g. Testing method: PCR IHC Culture Next-generation sequencing
 Unknown
 - a. PCR Results: Positive Negative Results not available
 - b. IHC Results: Positive Negative Results not available
 - c. Culture Results: Positive Negative Results not available
 - d. NGS Results: Positive Negative Results not available

13. Did this patient have an osteoarticular infection (e.g. osteomyelitis or spondylodiscitis) caused by *Coxiella burnetii*? Yes No Unknown

(If 'no' or 'unknown', skip to question 14)

- a. Please specify location of osteoarticular infection : _____
- b. Was this a native joint? Yes No Unknown
- c. Was surgical debridement of the diseased tissue and bone performed? Yes No
Unknown
(If 'no' or 'unknown', skip to question 14)

- d. If yes, specify date of most recent debridement: _____ (mm/yyyy)
- e. During the debridement, was any tissue tested for presence of *Coxiella burnetii*? Yes No
 Unknown
(If 'no' or 'unknown', skip to question 14)
- f. Testing method: PCR IHC Culture Next-generation sequencing
 Unknown
- a. PCR Results: Positive Negative Results not available
- b. IHC Results: Positive Negative Results not available
- c. Culture Results: Positive Negative Results not available
- d. NGS Results: Positive Negative Results not available
- 14. Did this patient have evidence of granulomatous hepatitis?** Yes No Unknown
(If 'no' or 'unknown', skip to question 15)
- a. Which of the following liver enzymes was elevated? (check all that apply)
 Alk Phos ALT AST LDH Bilirubin
- b. Was a liver biopsy performed? Yes No Unknown
(If 'no' or 'unknown', skip to question 15)
- c. Was the biopsy tested for presence of *Coxiella burnetii*? Yes No Unknown
(If 'no' or 'unknown', skip to question 15)
- d. Testing method: PCR IHC Culture Next-generation sequencing Unknown
- a. PCR Results: Positive Negative Results not available
- b. IHC Results: Positive Negative Results not available
- c. Culture Results: Positive Negative Results not available
- d. NGS Results: Positive Negative Results not available
- 15. Did this patient develop lymphadenopathy?** Yes No Unknown
(If 'no' or 'unknown', skip to question 16)
- a. Please specify location of lymphadenopathy(s): (check all that apply)
 Cervical Supraclavicular Axillary Perihilar Mediastinal
 Mesenteric Inguinal Popliteal
 Other: _____
- b. Was a lymph node biopsy performed? Yes No Unknown
(If 'no' or 'unknown', skip to question 16)
- c. Was the biopsy tested for presence of *Coxiella burnetii*? Yes No Unknown
(If 'no' or 'unknown', skip to question 16)
- d. Testing method: PCR IHC Culture Next-generation sequencing
 Unknown
- a. PCR Results: Positive Negative Results not available
- b. IHC Results: Positive Negative Results not available
- c. Culture Results: Positive Negative Results not available
- d. NGS Results: Positive Negative Results not available
- 16. Did this patient develop either of the following complications? (check all that apply)**
 Psoas abscess Cardiac abscess Empyema or other pulmonary abscess
 Other abscess → please specify location(s): _____
 Ruptured aneurism
 None of the above
(If none of the above selected, skip to question 17.)
- a. Was medical intervention performed? Yes No Unknown
(If 'no' or 'unknown', skip to question 17)

- b. What interventions were performed? incision and drainage marsupialization
 indwelling drain Other, specify _____
- c. Was any material from the abscess or rupture tested for *Coxiella burnetii*? Yes No
 Unknown
(If 'no' or 'unknown' skip to question 17.)
- d. What was the method used to test material from the abscess?
 PCR IHC Culture Unknown
- e. What was the result of testing? Positive Negative Results not available

17. Did this patient develop an embolic stroke or infarct? Yes No Unknown

(If 'no' or 'unknown', skip to question 18.)

- a. Please specify location: _____
- b. Date of stroke or infarct occurrence: _____ (mm/dd/yyyy)

18. Was this patient admitted to the hospital for this illness? Yes No Unknown

(If 'no' or 'unknown', skip to question 19.)

- a. First date of admission: __/__/____ and date of discharge: __/__/____
- b. Please provide the number of times the patient was hospitalized at least overnight for complications of chronic Q fever since the initial chronic Q diagnosis. _____

19. Which antibiotics did the patient receive? Doxycycline Hydroxychloroquine None Other
 _____ (please write name of medication)

- a. How long has/was the patient on antibiotic therapy? _____ (months)
- b. Has the patient completed antibiotic therapy? Yes No Unknown
- c. Was the patient taken off any antibiotic during treatment due to side effects? Yes No
 Unknown *(If 'no' or 'unknown', skip to question 19e.)*
- d. *If yes which medication (s) were stopped?* Doxycycline Hydroxychloroquine Other

- e. *And what were the side effects?* nausea vomiting fatigue photosensitivity
 Other: _____ Unknown
- f. Did the patient develop any of the following side effects or complications from antibiotic therapy (select all that apply)?
- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea/other GI upset | <input type="checkbox"/> Retinal damage | <input type="checkbox"/> QT prolongation |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> irreversible skin pigmentation | |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None | |

20. On average, how frequently were Q fever serologies collected from the patient? Every _____ months
 (on average)

- a. What was the **highest** Phase 1 IgG titer value recorded date _____
- b. What was the **highest** Phase 2 IgG titer value recorded date _____
- c. What was the **lowest** Phase 1 IgG titer value recorded date _____
- d. What was the **lowest** Phase 2 IgG titer value recorded date _____

21. Did the patient die from complications of this illness? Yes No Unknown

(If 'no' or 'unknown', skip to end of survey.)

- a. Date of death: __/__/____
- b. Cause of death per death certificate: _____