Form Approved
OMB No. 0920-1385
Exp. Date: 3/31/26

Coccidioidomycosis Case Report Form

Unique patient ID (State initials + unique state ID): _____

NNDSS State ID: _____ ◻ Not applicable

NORS ID: _____ ◻ Not applicable

EIP laboratory ID: _____ ◻ Not applicable

Form completion data
Name of person completing this form: _____ Institution: _____ Email: _____ Telephone: _____ Date form completed: _____ Date reporting jurisdiction was first notified (if applicable): _____-_____-_____ (mm-dd-yyyy) Date reported to EIP site (if applicable): _____-_____-_____ (mm-dd-yyyy) Date chart abstraction completed (if applicable): _____-_____-_____ (mm-dd-yyyy) Date patient interview completed (if applicable): _____-_____-_____ (mm-dd-yyyy) CRF status: ◻ Complete ◻ Pending ◻ Chart unavailable *Date of incident specimen collection* (DISC)*: _____-_____-_____ (mm-dd-yyyy) *This is the date of specimen collection for the patient's first positive coccidioidomycosis test

A. Case Surveillance Information
Reporting state/jurisdiction: _____ Reporting county: _____ Case classification status: ◻ Confirmed ◻ Probable ◻ Suspect ◻ Not a case ◻ Unknown

CHART REVIEW

B. Patient Demographics	
1. Age at DISC: (use months or days if patient was aged <2 years)	_____ ◻ Years ◻ Months ◻ Days ◻ Unknown
2. Assigned sex at birth	◻ Male ◻ Female ◻ Unknown
3. Gender identity	◻ Male ◻ Female ◻ Transgender, non-binary, or another gender ◻ Prefer not to answer/Decline ◻ Unknown
4. What is your race and/or ethnicity? (select all that apply and enter additional details in the spaces provided)	◻ American Indian or Alaska Native *Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.* _____ ◻ Asian – provide details below ◻ Chinese ◻ Asian Indian ◻ Filipino ◻ Vietnamese ◻ Korean ◻ Japanese *Enter, for example, Pakistani, Hmong, Afghan, etc.* _____ ◻ Black or African American – provide details below

	□ African American □ Jamaican □ Haitian □ Nigerian □ Ethiopian □ Somali *Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.* _____ □ Hispanic or Latino – provide details below □ Mexican □ Puerto Rican □ Salvadoran □ Cuban □ Dominican □ Guatemalan *Enter, for example, Colombian, Honduran, Spaniard, etc.* _____ □ Middle Eastern or North African – provide details below □ Lebanese □ Iranian □ Egyptian □ Syrian □ Iraqi □ Israeli *Enter, for example, Moroccan, Yemeni, Kurdish, etc.* _____ □ Native Hawaiian or Pacific Islander – provide details below □ Native Hawaiian □ Samoan □ Chamorro □ Tongan □ Fijian □ Marshallese *Enter, for example, Chuukese, Palauan, Tahitian, etc.* _____ □ White – provide details below □ English □ German □ Irish □ Italian □ Polish □ Scottish *Enter, for example, French, Swedish, Norwegian, etc.* _____
5. Patient's country of primary residence (e.g., USA)	_____ □ Unknown
6. Patient's state, jurisdiction, or territory of primary residence	_____ □ Unknown
7. Patient's county of primary residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"):	_____ □ Unknown
8. Patient's city of primary residence	_____ □ Unknown
9. Patient's ZIP code of primary residence	_____ □ Unknown
10. Patient's type of health insurance at DISC	□ Private □ Medicare □ Medicaid/state assistance program □ Military □ Indian Health Service □ Incarcerated □ Uninsured □ Other (specify): _____ □ Unknown

C. Patient underlying risk factors & medical conditions present during the 2 years before DISC (unless other timeframe specified)	
1. Cancer □ Yes □ No □ Unknown □ Hematologic malignancy specify malignancy: _____ □ Solid organ malignancy specify organ:_____ □ Chemotherapy If yes, specify therapy type: _____	2. HIV infection □ Yes □ No □ Unknown If yes, choose one of the below *Ever* had CD4 < 200 cells/mm^3 within past 6 months □ Yes □ No □ Unknown
3. Chronic pulmonary diagnosis □ Yes □ No □ Unknown □ Chronic obstructive pulmonary disease (COPD) or emphysema □ Bronchiectasis □ Cystic fibrosis □ Allergic bronchopulmonary aspergillosis (ABPA) □ Pulmonary fibrosis □ Asthma □ Interstitial Lung Disease □ Other chronic pulmonary diagnosis (specify):_____	4. Any respiratory viral test in 120 **days before or after DISC** □ Yes □ No □ Unknown If yes, (select all that apply): □ SARS-CoV-2 (PCR or antigen test) Date of specimen collection (mm/dd/yyyy): _____ □ Positive □ Negative □ Unknown □ Influenza Date of specimen collection (mm/dd/yyyy): _____ □ Positive □ Negative □ Unknown□ Other respiratory virus (specify) _____ Date of specimen collection (mm/dd/yyyy): _____ □ Positive □ Negative □ Unknown
5. Transplant received within 2 years before DISC	6. Other selected conditions:

□ Yes □ No □ Unknown □ Solid organ transplant: □ Lung □ Heart □ Kidney □ Pancreas □ Liver □ Skin graft □Other:_____ □ Unknown □ Hematopoietic stem cell transplant (HSCT)	□ None □ Cardiovascular disease (specify): _____ □ Diabetes mellitus □ End stage renal disease/dialysis □ Autoimmune disease(s) or inherited immunodeficiency(-ies) (specify): _____ □ Medications/therapies that weaken the immune system □ TNF-alpha inhibitors (e.g., infliximab, adalimumab, etanercept) □ Other (specify): _____ □ Cirrhosis □ Liver disease without cirrhosis □ Systemic lupus erythematosus □ Active tuberculosis □ Pregnant □ Pregnant on DISC Gestational age (weeks):_____ Unknown □ Post-partum (gave birth within 6 weeks before DISC)
7. Please list any other potentially relevant clinical information: _____ _____ _____ _____ _____	

D. Social History	
1. Smoking (select all that apply)	□ Tobacco, current □ Tobacco, previous □ E-nicotine delivery system, current □ E-nicotine delivery system, previous □ None □ Unknown
2. Documented alcohol use disorder	□ Yes □ No □ Unknown
3. Cannabis use	□ Yes, with documented use disorder □ Yes, without documented use disorder □ No □ Unknown
4. Other illicit substance use	□ Yes, specify other illicit substance(s): _____ □ No □ Unknown

E. Laboratory data (specimen and testing data)

1. Specimen collection date: _____/_____/_____

2. Location of specimen collection:

□ Hospital inpatient □ Intensive care unit □ Surgery/OR □ Radiology □ Other inpatient _____	□ Outpatient □ Emergency room □ Clinic/Provider's office □ Dialysis center □ Surgery □ Urgent care □ Observational/clinical decision unit □ Other outpatient _____	□ Long-term care facility (LTCF) □ Long-term acute care hospital (LTACH) □ Autopsy □ Other _____ □ Unknown

Serology

□ Serum	Result:	Laboratory where testing was performed:
□ ID IgG	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ ID IgM	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ CF IgG	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ EIA IgG	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ EIA IgM	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp

□ Other: _____	□ Pos. □ Neg. □ Unclear □ Unk.	□ Other_____ □ Unk. □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ CSF □ ID IgG	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ ID IgM	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ CF IgG	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ EIA IgG	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ EIA IgM	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ Other: _____	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
Antigen		
□ Serum	Result: □ Pos., titer: ____ □ Neg. □ Unclear □ Unk. Below limit of quantification? □ Yes □ No □ Unk.	Laboratory: □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.
□ Urine	□ Pos., titer: ____ □ Neg. □ Unclear □ Unk. Below limit of quantification? □ Yes □ No □ Unk.	□ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp □ Other_____ □ Unk.

Other laboratory methods	
□ Bronchial specimen □ Culture	Result: □ Pos. □ Neg. □ Unclear □ Unk. □ *C. immitis* □ *C. posadasii* □ Pending □ Unk.
□ Direct smear/cytology	□ Pos. □ Neg. □ Unclear □ Unk.
□ Molecular test (e.g., PCR)	□ Pos. □ Neg. □ Unclear □ Unk.
Specify test: _____	
□ Other _____	□ Pos. □ Neg. □ Unclear □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.
□ Sputum □ Culture	Result: □ Pos. □ Neg. □ Unclear □ Unk. □ *C. immitis* □ *C. posadasii* □ Pending □ Unk.
□ Direct smear/cytology	□ Pos. □ Neg. □ Unclear □ Unk.
□ Molecular test (e.g., PCR)	□ Pos. □ Neg. □ Unclear □ Unk.
Specify test: _____	
□ Other _____	□ Pos. □ Neg. □ Unclear □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.
□ Urine □ Culture	Result: □ Pos. □ Neg. □ Unclear □ Unk. □ *C. immitis* □ *C. posadasii* □ Pending □ Unk.
□ Other _____	□ Pos. □ Neg. □ Unclear □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.
□ Lung tissue □ Culture	Result: □ Pos. □ Neg. □ Unclear □ Unk. □ *C. immitis* □ *C. posadasii* □ Pending □ Unk.
□ Histopathology	□ Pos. □ Neg. □ Unclear □ Unk.
□ Molecular test (e.g., PCR)	□ Pos. □ Neg. □ Unclear □ Unk.
Specify test: _____	
□ Other _____	□ Pos. □ Neg. □ Unclear □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.
□ Other specimen _____	Result:

□ Culture	□ Pos. □ Neg. □ Unclear □ Unk. □ *C. immitis* □ *C. posadasii* □ Pending □ Unk.
□ Histopathology	□ Pos. □ Neg. □ Unclear □ Unk.
□ Direct smear/cytology	□ Pos. □ Neg. □ Unclear □ Unk.
□ Molecular test (e.g., PCR) Specify test: _____	□ Pos. □ Neg. □ Unclear □ Unk.
□ Other _____	□ Pos. □ Neg. □ Unclear □ Unk.
□ Unknown	□ Pos. □ Neg. □ Unclear □ Unk.

F. Antifungal susceptibility testing			
Date of culture (mm/dd/yyyy)	**Species**	**Drug**	**MIC**
_____/_____/_____	□ *C. immitis* □ *C. posadasii* □ Unknown	Amphotericin B	
		Anidulafungin (Eraxis)	
		Caspofungin (Cancidas)	
		Fluconazole (Diflucan)	
		Flucytosine (5FC)	
		Ibrexafungerp (Brexafemme)	
		Isavuconazole (Cresemba)	
		Itraconazole (Sporanox)	
		Micafungin (Mycamine)	
		Posaconazole (Noxafil)	
		Voriconazole (Vfend)	

G. Patient symptoms, diagnosis, and outcomes	
1. Acute signs/symptoms on or within 60 days before DISC?	□ Yes □ No acute signs or symptoms □ Unknown
1a. Symptoms experienced on or within 60 days before DISC (select all that apply).	**Pulmonary:** □ Cough □ Hemoptysis □ Wheezing □ Shortness of Breath **Other respiratory infection symptoms**: □ Sore throat □ Chest pain □ Chills □ Night Sweats □ Fever □ Fatigue □ Stiff neck □ Headache □ Joint or bone pain or body aches □ Weight loss without trying □ Muscle pain □ Nausea □ Vomiting **Dermal:** □ Rash or other skin problems ((□ Erythema nodosum □ Erythema multiforme □ Other (specify) _____)) **Neurologic:** □ Confusion □ Seizures **Radiologic findings:** □ Abnormal findings on chest imaging (e.g., pulmonary infiltrates, cavitation, nodules, or lesions) □ Peripheral lymphadenopathy □ Bone or joint abnormality (e.g., osteomyelitis, pathologic fracture) □ Meningitis, encephalitis, or focal brain lesion □ Abscess, granuloma, or lesion in other system □ No acute signs/symptoms □ Other (specify) _____
2. Date of earliest symptom onset?	_____/_____/_____ (mm/dd/yyyy) □ If exact date unknown, approximate date of onset: _____ □ No acute signs/symptoms □ Unknown
3. Was the patient part of an outbreak of suspected fungal infections?	□ Yes □ No □ Unknown
4. Did the patient request to be tested for	□ Yes □ No □ Unknown

coccidioidomycosis?	
5. According to treating clinicians, which clinical syndrome(s) related to *Coccidioides* did the patient have on or within 60 days after DISC?	□ Acute pulmonary coccidioidomycosis □ Chronic pulmonary coccidioidomycosis □ Coccidioidomycosis lung granuloma Was lung granuloma an incidental finding? □ Yes □ No □ Unknown □ Disseminated coccidioidomycosis □ Coccidioidomycosis meningitis Treated with a ventriculoperitoneal (VP) shunt? □ Yes □ No □ Unknown □ Focal coccidioidomycosis (specify site): _____ □ Unknown
6. What other clinical diagnoses did the patient have on or within 60 days before DISC? (select all that apply)	□ Blastomycosis □ Cryptococcosis □ Histoplasmosis □ Other fungal infection (specify): _____ □ Community-acquired pneumonia □ Bacterial pneumonia □ Viral pneumonia □ Cancer □ Tuberculosis □ Influenza □ COVID-19 □ Other infection/disease not listed (specify): _____ □ None □ Unknown
7. Site of *Coccidioides* infection based on clinical impression on or within 60 days after DISC (select all that apply)	□ Lung □ Skin □ Bone □ Joint □ Central nervous system □ No site identified □ Other (specify) _____ □ Unknown
8. Was the patient hospitalized at an acute care hospital in the 60 days before to 60 days after DISC?	□ Yes □ No □ Unknown *If yes*, dates of admission of hospitalization most proximal to DISC, Admission date: _____/_____/_____ (mm/dd/yyyy) Discharge date: _____/_____/_____ (mm/dd/yyyy) □ still hospitalized *If yes*, Received ICU-level care in the 14 days *before* DISC?: □ yes □ no □ unknown Received ICU-level care in the 14 days *after* DISC?: □ yes □ no □ unknown Discharge ICD-10 diagnosis code(s): _____
9. Died within 60 days after DISC?	□ No □ Yes, date of death _____ / _____/ _____ (mm/dd/yyyy) Cause(s) of death _____ If yes, did death occur in hospital? □ Yes □ No □ Unknown □ Unknown
10. Did the patient have any outpatient, urgent care, and/or emergency department visits in the 60 days before to 60 days after DISC?	□ Yes □ No □ Unknown If yes, how many visits? _____ (if more than one, fill out information below for each visit) Date of visit: _____/_____/_____ (mm/dd/yyyy) If date of visit is after DISC, was the visit related to coccidioidomycosis? □ Yes □ No □ Unknown Setting: □ Primary care □ Urgent care □ Emergency department □ Specialty care: Pulmonology □ Specialty care: Infectious Disease □ Other (specify): Chief complaint: _____ □ Not listed □ Unknown Was coccidioidomycosis noted as a possible diagnosis? □ Yes □ No □ Unknown Did the visit involve fever or recent onset of respiratory symptoms? □ Yes □ No □ Unknown
11. Was a chest x-ray taken within 60 days before to 60 days after DISC?	□ Yes □ No □ Unknown If yes, were any of the chest x-rays abnormal □ Yes □ No □ Unknown

	Date of first abnormal chest x-ray: _____/_____/_____ (mm/dd/yyyy) For first abnormal chest x-ray, select all that apply; □ Air space density □ Air space opacity □ Consolidation □ Cavitary lesions □ Granuloma □ Pulmonary infiltrate □ Interstitial infiltrate □ Lobar infiltrate □ Nodule □ Report not available □ Other (specify): _____ □ Unknown
12. Was a chest CT scan taken within 90 days before to 60 days after DISC?	□ Yes □ No □ Unknown If yes, were any of the chest CT scans abnormal □ Yes □ No □ Unknown Date of first abnormal chest CT scan: _____/_____/_____ (mm/dd/yyyy) For first abnormal chest CT scan, select all that apply; □ Air space density □ Air space opacity □ Consolidation □ Cavitary lesions □ Granuloma □ Pulmonary infiltrate □ Interstitial infiltrate □ Lobar infiltrate □ Nodule □ Report not available □ Other (specify): _____ □ Unknown

H. Vital Status	
1. Has the patient died?	□ No □ Yes, date of death _____ / _____/_____ (mm/dd/yyyy) Cause(s) of death _____ If yes, did death occur in hospital? □ Yes □ No □ Unknown □ Unknown

I. Antifungal Treatment

1. Did the patient receive antifungal drugs during the 90 days before to 60 days after the DISC? □ Yes □ No □ Unknown
(If yes, please complete the table below for each drug received)

Select one of the following to complete each row of the table:

Amphotericin B lipid complex (ABLC)
Liposomal Amphotericin B (L-AmB)
Amphotericin B coloidal dispersion (ABCD)
Anidulafungin (ANF)
Caspofungin (CAS)
Fluconazole (FLC)
Flucytosine (5FC)
Ibrexafungerp (IBR)
Isavuconazole (ISA)
Itraconazole (ITC)
Micafungin (MFG)
Posaconazole (PSC)
Voriconazole (VRC)
Other drug (OTH), specify:_____
Unknown drug (UNK)

Drug abbrev.	First date given (mm/dd/yyyy)	Last date given (mm/dd/yyyy)	Indication	Therapeutic Drug Monitoring (TDM)
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	□ Prophylaxis □ Treatment for *Coccidioides* □ Treatment for non-*Coccidioides* infection	□ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: □ No
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	□ Prophylaxis □ Treatment for *Coccidioides* □ Treatment for non-*Coccidioides* infection	□ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: □ No
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	□ Prophylaxis □ Treatment for *Coccidioides* □ Treatment for non-*Coccidioides* infection	□ Yes Date of earliest TDM: TDM level: Date of second TDM:

				TDM level: □ No
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	□ Prophylaxis □ Treatment for *Coccidioides* □ Treatment for non-*Coccidioides* infection	□ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: □ No

PATIENT INTERVIEW

J. Supplemental Patient Interview Form Note that the "you" in these questions refers to the patient.	
1. Person interviewed	□ Patient □ Someone other than the patient, (specify relationship to patient): _____
2. Were you told that you had a positive lab result for coccidioidomycosis before our call today?	□ Yes If yes, what type of healthcare setting told you? □ Emergency room □ Urgent care □ Primary care □ Hospital □ Pharmacy □ Public health official □ Other (specify): _____ □ No If no, were you told that you had a negative lab result for coccidioidomycosis before our call today? □ Yes □ No □ Unsure □ Unsure If unsure, were you told that you had a negative lab result for coccidioidomycosis before our call today? □ Yes □ No □ Unsure
3. Do you currently or have you ever lived in or traveled to following areas? (select all that apply)	□ Arizona, specify city/cities/dates: _____ □ California, specify city/cities/dates: _____ □ Nevada, specify city/cities/dates: _____ □ New Mexico, specify city/cities/dates: _____ □ Texas, specify city/cities/dates: _____ □ Utah, specify city/cities/dates: _____ □ Washington, specify city/cities/dates: _____ □ International, specify country/city/cities/dates: _____ □ None □ Don't know
4. Have you lived in, worked in, or traveled to any other states or countries listed above in the past 6 months before testing positive for coccidioidomycosis or symptom onset?	□ United States, specify:_____ □ International, specify: _____
5. In the six weeks before testing positive for coccidioidomycosis or symptom onset, which of the following outdoor activities did you participate in within an area known to have the fungus that causes coccidioidomycosis (select all that apply)?	□ Walking/walking your pet □ Biking/running outside □ Gardening/yard work □ Off roading/outdoor vehicle □ Rodeo/roping/horseback riding □ Hiking □ Outdoor sports, specify □ Other outdoor activity, specify □ None □ Don't know
6. In the six weeks before testing positive for coccidioidomycosis, what kind of work did you do? If you did more than one type of job in the six weeks before you were tested, please tell us about each one:	_____ □ Student □ Unemployed □ Retired □ Not applicable □ Unknown
7. In the six weeks before testing positive for coccidioidomycosis, what kind of industry did you work in? If you worked in more than one industry in the six weeks before you were tested, please tell us about each one:	_____ □ Student □ Unemployed □ Retired □ Not applicable □ Unknown
8. How often did you work, travel, or volunteer outdoors in the 6 weeks before testing positive for coccidioidomycosis?	□ Every day □ Most days □ Some days

	□ Rarely □ Never □ N/A □ Don't know
9. How often did you dig or disturb dirt in the 6 weeks before testing positive for coccidioidomycosis?	□ Every day □ Most days □ Some days □ Rarely □ Never □ N/A □ Don't know
10. How frequently were you exposed to outdoor dust in the 6 weeks before testing positive for coccidioidomycosis?	□ Every day □ Most days □ Some days □ Rarely □ Never □ N/A □ Don't know
11. How often did you wear a respirator like an N95 or KN95 or a mask if you were exposed to dust at work?	□ Every day □ Most days □ Some days □ Rarely □ Never □ N/A □ Don't know
12. Did you miss school or work because of coccidioidomycosis?	□ Yes, number of days _____ □ No □ N/A □ Don't know
13. Had you ever heard of coccidioidomycosis (also known as Valley Fever or cocci) before you were diagnosed or told of your positive result?	□ Yes If yes, where did you hear about it? (check all that apply) □ Healthcare provider □ Internet □ Family member, friend, coworker □ Radio □ Television □ Don't know □ Other, specify □ No □ Don't know
14. How do you think people get coccidioidomycosis? (check all that apply)	□ From another person □ From animals □ From food □ From bug bites □ From water □ From the environment □ Other, specify: _____ □ Don't know

Additional comments:

_____

_____

_____

_____

_____