

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. Sex

☐ Male ☐ Female

3. 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.

CDC estimates the average public reporting burden for this collection of information as 60 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA (0920-1385).

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

C. Patient underlying risk factors & medical conditions present during the 2 years before DISC (unless other timeframe specified)	
1. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Hematologic malignancy specify malignancy: _____ <input type="checkbox"/> Solid organ malignancy specify organ: _____ <input type="checkbox"/> Chemotherapy If yes, specify therapy type: _____	2. HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, choose one of the below Ever had CD4 < 200 cells/mm ³ within past 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3. Chronic pulmonary diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) or emphysema <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Allergic bronchopulmonary aspergillosis (ABPA) <input type="checkbox"/> Pulmonary fibrosis <input type="checkbox"/> Asthma <input type="checkbox"/> Interstitial Lung Disease <input type="checkbox"/> Other chronic pulmonary diagnosis (specify): _____	4. Any respiratory viral test in 120 days before or after DISC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, (select all that apply): <input type="checkbox"/> SARS-CoV-2 (PCR or antigen test) Date of specimen collection (mm/dd/yyyy): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Influenza Date of specimen collection (mm/dd/yyyy): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Other respiratory virus (specify) _____ Date of specimen collection (mm/dd/yyyy): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
5. Transplant received within 2 years before DISC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	6. Other selected conditions: <input type="checkbox"/> None <input type="checkbox"/> Cardiovascular disease

<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> CSF <input type="checkbox"/> ID IgG <input type="checkbox"/> ID IgM <input type="checkbox"/> CF IgG <input type="checkbox"/> EIA IgG <input type="checkbox"/> EIA IgM <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos., titer: _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos., titer: _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos., titer: _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
Antigen		
<input type="checkbox"/> Serum <input type="checkbox"/> Urine	Result: <input type="checkbox"/> Pos., titer: _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. Below limit of quantification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> Pos., titer: _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. Below limit of quantification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	Laboratory: <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk. <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.

Other laboratory methods	
<input type="checkbox"/> Bronchial specimen <input type="checkbox"/> Culture <input type="checkbox"/> Direct smear/cytology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>C. immitis</i> <input type="checkbox"/> <i>C. posadasii</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Sputum <input type="checkbox"/> Culture <input type="checkbox"/> Direct smear/cytology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>C. immitis</i> <input type="checkbox"/> <i>C. posadasii</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Urine <input type="checkbox"/> Culture <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>C. immitis</i> <input type="checkbox"/> <i>C. posadasii</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Lung tissue <input type="checkbox"/> Culture <input type="checkbox"/> Histopathology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>C. immitis</i> <input type="checkbox"/> <i>C. posadasii</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Other specimen _____ <input type="checkbox"/> Culture	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>C. immitis</i> <input type="checkbox"/> <i>C. posadasii</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unk.

<input type="checkbox"/> Histopathology <input type="checkbox"/> Direct smear/cytology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
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F. Antifungal susceptibility testing			
Date of culture (mm/dd/yyyy)	Species	Drug	MIC
____/____/____	<input type="checkbox"/> <i>C. immitis</i> <input type="checkbox"/> <i>C. posadasii</i> <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No acute signs or symptoms <input type="checkbox"/> Unknown
1a. Symptoms experienced on or within 60 days before DISC (select all that apply).	Pulmonary: <input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath Other respiratory infection symptoms: <input type="checkbox"/> Sore throat <input type="checkbox"/> Chest pain <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Stiff neck <input type="checkbox"/> Headache <input type="checkbox"/> Joint or bone pain or body aches <input type="checkbox"/> Weight loss without trying <input type="checkbox"/> Muscle pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting Dermal: <input type="checkbox"/> Rash or other skin problems ((<input type="checkbox"/> Erythema nodosum <input type="checkbox"/> Erythema multiforme <input type="checkbox"/> Other (specify) _____)) Neurologic: <input type="checkbox"/> Confusion <input type="checkbox"/> Seizures Radiologic findings: <input type="checkbox"/> Abnormal findings on chest imaging (e.g., pulmonary infiltrates, cavitation, nodules, or lesions) <input type="checkbox"/> Peripheral lymphadenopathy <input type="checkbox"/> Bone or joint abnormality (e.g., osteomyelitis, pathologic fracture) <input type="checkbox"/> Meningitis, encephalitis, or focal brain lesion <input type="checkbox"/> Abscess, granuloma, or lesion in other system <input type="checkbox"/> No acute signs/symptoms <input type="checkbox"/> Other (specify) _____
2. Date of earliest symptom onset?	____/____/____ (mm/dd/yyyy) <input type="checkbox"/> If exact date unknown, approximate date of onset: _____ <input type="checkbox"/> No acute signs/symptoms <input type="checkbox"/> Unknown
3. Was the patient part of an outbreak of suspected fungal infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4. Did the patient request to be tested for coccidioidomycosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

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

H. Vital Status	
1. Has the patient died?	<input type="checkbox"/> No <input type="checkbox"/> Yes, date of death ____ / ____ / ____ (mm/dd/yyyy) Cause(s) of death _____ If yes, did death occur in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

I. Antifungal Treatment				
1. Did the patient receive antifungal drugs during the <u>90 days before to 60 days after</u> the DISC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)	Fluconazole (FLC)	Micafungin (MFG)		
Liposomal Amphotericin B (L-AmB)	Flucytosine (5FC)	Posaconazole (PSC)		
Amphotericin B colloidal dispersion (ABCD)	Ibrexafungerp (IBR)	Voriconazole (VRC)		
Anidulafungin (ANF)	Isavuconazole (ISA)	Other drug (OTH), specify: _____		
Caspofungin (CAS)	Itraconazole (ITC)	Unknown drug (UNK)		
Drug abbrev.	First date given (mm/dd/yyyy)	Last date given (mm/dd/yyyy)	Indication	Therapeutic Drug Monitoring (TDM)
	____/____/____	____/____/____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Coccidioides</i> <input type="checkbox"/> Treatment for non- <i>Coccidioides</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: _____ TDM level: _____ Date of second TDM: _____ TDM level: _____ <input type="checkbox"/> No
	____/____/____	____/____/____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Coccidioides</i> <input type="checkbox"/> Treatment for non- <i>Coccidioides</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: _____ TDM level: _____ Date of second TDM: _____ TDM level: _____ <input type="checkbox"/> No
	____/____/____	____/____/____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Coccidioides</i> <input type="checkbox"/> Treatment for non- <i>Coccidioides</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: _____ TDM level: _____ Date of second TDM: _____ TDM level: _____

				<input type="checkbox"/> No
	___/___/___	___/___/___	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Coccidioides</i> <input type="checkbox"/> Treatment for non- <i>Coccidioides</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: <input type="checkbox"/> No

PATIENT INTERVIEW

J. Supplemental Patient Interview Form	
Note that the "you" in these questions refers to the patient.	
1. Person interviewed	<input type="checkbox"/> Patient <input type="checkbox"/> 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?	<input type="checkbox"/> Yes If yes, what type of healthcare setting told you? <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care <input type="checkbox"/> Primary care <input type="checkbox"/> Hospital <input type="checkbox"/> Pharmacy <input type="checkbox"/> Public health official <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> No If no, were you told that you had a negative lab result for coccidioidomycosis before our call today? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Unsure If unsure, were you told that you had a negative lab result for coccidioidomycosis before our call today? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
3. Do you currently or have you ever lived in or traveled to following areas? (select all that apply)	<input type="checkbox"/> Arizona, specify city/cities/dates: _____ <input type="checkbox"/> California, specify city/cities/dates: _____ <input type="checkbox"/> Nevada, specify city/cities/dates: _____ <input type="checkbox"/> New Mexico, specify city/cities/dates: _____ <input type="checkbox"/> Texas, specify city/cities/dates: _____ <input type="checkbox"/> Utah, specify city/cities/dates: _____ <input type="checkbox"/> Washington, specify city/cities/dates: _____ <input type="checkbox"/> International, specify country/city/cities/dates: _____ <input type="checkbox"/> None <input type="checkbox"/> 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?	<input type="checkbox"/> United States, specify: _____ <input type="checkbox"/> 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)?	<input type="checkbox"/> Walking/walking your pet <input type="checkbox"/> Biking/running outside <input type="checkbox"/> Gardening/yard work <input type="checkbox"/> Off roading/outdoor vehicle <input type="checkbox"/> Rodeo/roping/horseback riding <input type="checkbox"/> Hiking <input type="checkbox"/> Outdoor sports, specify _____ <input type="checkbox"/> Other outdoor activity, specify _____ <input type="checkbox"/> None <input type="checkbox"/> 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:	_____ <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Not applicable <input type="checkbox"/> 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:	_____ <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown
8. How often did you work, travel, or volunteer outdoors in the 6 weeks before testing positive for coccidioidomycosis?	<input type="checkbox"/> Every day <input type="checkbox"/> Most days <input type="checkbox"/> Some days <input type="checkbox"/> Rarely

	<input type="checkbox"/> Never <input type="checkbox"/> N/A <input type="checkbox"/> Don't know
9. How often did you dig or disturb dirt in the 6 weeks before testing positive for coccidioidomycosis?	<input type="checkbox"/> Every day <input type="checkbox"/> Most days <input type="checkbox"/> Some days <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> N/A <input type="checkbox"/> Don't know
10. How frequently were you exposed to outdoor dust in the 6 weeks before testing positive for coccidioidomycosis?	<input type="checkbox"/> Every day <input type="checkbox"/> Most days <input type="checkbox"/> Some days <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> N/A <input type="checkbox"/> 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?	<input type="checkbox"/> Every day <input type="checkbox"/> Most days <input type="checkbox"/> Some days <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> N/A <input type="checkbox"/> Don't know
12. Did you miss school or work because of coccidioidomycosis?	<input type="checkbox"/> Yes, number of days _____ <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <div style="margin-left: 40px;">If yes, where did you hear about it? (check all that apply)</div> <div style="margin-left: 40px;"> <input type="checkbox"/> Healthcare provider <input type="checkbox"/> Internet <input type="checkbox"/> Family member, friend, coworker <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Don't know <input type="checkbox"/> Other, specify _____ </div> <input type="checkbox"/> No <input type="checkbox"/> Don't know
14. How do you think people get coccidioidomycosis? (check all that apply)	<input type="checkbox"/> From another person <input type="checkbox"/> From animals <input type="checkbox"/> From food <input type="checkbox"/> From bug bites <input type="checkbox"/> From water <input type="checkbox"/> From the environment <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Don't know

Additional comments: