**Histoplasmosis 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

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| **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 histoplasmosis test |

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| **A. Case Surveillance Information** |
| Reporting state/jurisdiction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reporting county*: \_\_\_\_\_\_\_\_\_\_\_\_*  Case classification status: □ Confirmed □ Probable □ Suspect □ Not a case □ Unknown |

**CHART REVIEW**

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| **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.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ 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.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Patient’s country of primary residence (e.g., USA) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown |
| 5. Patient’s state, jurisdiction, or territory of primary residence | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown |
| 6. Patient's county of primary residence (Please do not write the word “County”; for example, write “Cook” instead of “Cook County”): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown |
| 7. Patient’s city of primary residence | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown |
| 8. Patient’s ZIP code of primary residence | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown |
| 9. Patient’s type of health insurance at DISC | □ Private □ Medicare □ Medicaid/state assistance program □ Military □ Indian Health Service □ Incarcerated □ Uninsured □ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown |

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| **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/mm3 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  □ Yes □ No □ Unknown    □ Solid organ transplant:  □ Lung □ Heart □ Kidney □ Pancreas □ Liver □ Skin graft □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unknown  □ Hematopoietic stem cell transplant (HSCT) | 6. Other selected conditions:  □ 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:  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | |

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| **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 |

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| **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  □ ID IgG  □ ID IgM    □ CF IgG    □ EIA IgG    □ EIA IgM    □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    □ Unknown  □ CSF  □ ID IgG    □ ID IgM    □ CF IgG  □ EIA IgG  □ EIA IgM  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown | Result:  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk. | | Laboratory where testing was performed:  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk. | |
| **Antigen** | | | | |
| □ Serum  □ Urine | Result:  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  Below limit of quantification?  □ Yes □ No □ Unk.  □ Pos., titer: \_\_\_\_ □ Neg. □ Unclear □ Unk.  Below limit of quantification?  □ Yes □ No □ Unk. | | Laboratory:  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk.  □ ARUP □ MiraVista □ Mayo □ Quest □ LabCorp  □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unk. | |

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| **Other laboratory methods** | |
| □ Bronchial specimen  □ Culture    □ Direct smear/cytology  □ Molecular test (e.g., PCR)  Specify test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown | Result:  □ Pos. □ Neg. □ Unclear □ Unk.  □ *H. capsulatum var. capsulatum* □ *H. capsulatum var. duboisii* □ Pending □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk. |
| □ Sputum  □ Culture    □ Direct smear/cytology  □ Molecular test (e.g., PCR)  Specify test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown | Result:  □ Pos. □ Neg. □ Unclear □ Unk.  □ *H. capsulatum var. capsulatum* □ *H. capsulatum var. duboisii* □ Pending □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk. |
| □ Urine  □ Culture    □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown | Result:  □ Pos. □ Neg. □ Unclear □ Unk.  □ *H. capsulatum var. capsulatum* □ *H. capsulatum var. duboisii* □ Pending □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk. |
| □ Lung tissue  □ Culture    □ Histopathology  □ Molecular test (e.g., PCR)  Specify test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown | Result:  □ Pos. □ Neg. □ Unclear □ Unk.  □ *H. capsulatum var. capsulatum* □ *H. capsulatum var. duboisii* □ Pending □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk. |
| □ Other specimen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Culture    □ Histopathology  □ Direct smear/cytology  □ Molecular test (e.g., PCR)  Specify test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown | Result:  □ Pos. □ Neg. □ Unclear □ Unk.  □ *H. capsulatum var. capsulatum* □ *H. capsulatum var. duboisii* □ Pending □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk.  □ Pos. □ Neg. □ Unclear □ Unk. |

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| **F. Antifungal susceptibility testing** | | | |
| **Date of culture (mm/dd/yyyy)** | **Species** | **Drug** | **MIC** |
| \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | □ *H. capsulatum var. capsulatum*  □ *H. capsulatum var. duboisii*  □ Unknown | Amphotericin B |  |
| Anidulafungin (Eraxis) |  |
| Caspofungin (Cancidas) |  |
| Fluconazole (Diflucan) |  |
| Flucytosine (5FC) |  |
| Ibrexafungerp (Brexafemme) |  |
| Isavuconazole (Cresemba) |  |
| Itraconazole (Sporanox) |  |
| Micafungin (Mycamine) |  |
| Posaconazole (Noxafil) |  |
| Voriconazole (Vfend) |  |

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| **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 histoplasmosis? | □ Yes □ No □ Unknown |
| 5. According to treating clinicians, which clinical syndrome(s) related to *Histoplasma* did the patient have on or within 60 days after DISC? | □ Acute pulmonary histoplasmosis  □ Subacute pulmonary histoplasmosis  □ Chronic pulmonary histoplasmosis  □ Progressive disseminated histoplasmosis  □ Histoplasmosis meningitis  Treated with a ventriculoperitoneal (VP) shunt? □ Yes □ No □ Unknown  □ Presumed ocular histoplasmosis syndrome (POHS)  □ Focal histoplasmosis (specify site): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Unknown |
| 6. What other clinical diagnoses did the patient have on or within 60 days before DISC? (select all that apply) | □ Blastomycosis  □ Coccidioidomycosis  □ Cryptococcosis  □ 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 *Histoplasma* 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 histoplasmosis? □ 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 histoplasmosis 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 |

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| **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 |

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| **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 *Histoplasma*  □ Treatment for non-*Histoplasma* infection | | □ Yes  Date of earliest TDM:  TDM level:  Date of second TDM:  TDM level:  □ No |
|  | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | □ Prophylaxis  □ Treatment for *Histoplasma*  □ Treatment for non-*Histoplasma* infection | | □ Yes  Date of earliest TDM:  TDM level:  Date of second TDM:  TDM level:  □ No |
|  | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | □ Prophylaxis  □ Treatment for *Histoplasma*  □ Treatment for non-*Histoplasma* infection | | □ Yes  Date of earliest TDM:  TDM level:  Date of second TDM:  TDM level:  □ No |
|  | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ | | □ Prophylaxis  □ Treatment for *Histoplasma*  □ Treatment for non-*Histoplasma* infection | | □ Yes  Date of earliest TDM:  TDM level:  Date of second TDM:  TDM level:  □ No |

**PATIENT INTERVIEW**

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| **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 histoplasmosis 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 histoplasmosis before our call today? □ Yes □ No □ Unsure  □ Unsure  If unsure, were you told that you had a negative lab result for histoplasmosis before our call today? □ Yes □ No □ Unsure |
| 3. Is your home located in an urban, suburban, or rural area? | □ Urban □ Suburban □ Rural, wooded □ Rural, farmland □ Don’t know |
| 4. In the four weeks before testing positive for histoplasmosis or symptom onset, did you travel out of your home county or state? | □ Yes, specify city/state/dates:  □ No  □ Don’t know |
| 5. In the four weeks before testing positive for histoplasmosis or symptom onset, which of the following outdoor activities did you participate in within an area known to have the fungus that causes histoplasmosis (select all that apply)? | □ Dig in soil  □ Go in a barn  □ Go in a cave  □ Handle bird poop  □ Handle bat poop  □ Clean a chicken coop  □ Construction  □ Demolition/renovation  □ Excavation  □ Clean attic/chimney  □ Hiking  □ Hunting  □ Camping  □ Heating/air conditioning work  □ Gardening/landscaping  □ Other handling of plants/trees  □ Outdoor sports, specify  □ Other outdoor activity, specify  □ None  □ Don’t know |
| 6. In the four weeks before testing positive for histoplasmosis, what kind of work did you do? If you did more than one type of job in the four weeks before you were tested, please tell us about each one: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Student □ Unemployed □ Retired □ Not applicable □ Unknown |
| 7. In the four weeks before testing positive for histoplasmosis, what kind of industry did you work in? If you worked in more than one industry in the four 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 four weeks before testing positive for histoplasmosis? | □ Every day  □ Most days  □ Some days  □ Rarely  □ Never  □ N/A  □ Don’t know |
| 9. In the four weeks before testing positive for histoplasmosis, how often did you wear a respirator like an N95 or KN95 or a mask at work? | □ Every day  □ Most days  □ Some days  □ Rarely  □ Never  □ N/A  □ Don’t know |
| 10. Did you miss school or work because of histoplasmosis? | □ Yes, number of days \_\_\_\_\_\_\_\_  □ No  □ N/A  □ Don’t know |
| 13. Had you ever heard of histoplasmosis 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 histoplasmosis? (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:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_