

One Health Harmful Algal Bloom System (OHHABS) Human Form

Form Approved

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Human Form

Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data 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 Information Collection Review Office, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA (0920-1105). DO NOT MAIL FORMS TO THIS ADDRESS

CDC REPORT ID	CDC FORM ID	STATE REPORT ID	REPORT DATE CREATED

GENERAL INFORMATION

Date illness reported to Health Department (MM/DD/YYYY): _____

Date of interview (MM/DD/YYYY): _____

HUMAN DESCRIPTION

Age: _____ ☐ Years ☐ Months

Sex: _____

State of Residence: _____

County of Residence: _____

What is the race and/or ethnicity of this person? *(Select all that apply)*

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Hispanic or Latino

☐ Middle Eastern or North African

☐ Native Hawaiian or Pacific Islander

☐ White

☐ Unknown

HUMAN EXPOSURE INFORMATION

Did exposure to algae, cyanobacteria, or toxins occur on a single date or multiple dates? (MM/DD/YYYY) *(Select one)*

☐ Single date

Date of exposure: _____

☐ Multiple dates

Date of first exposure: _____

Date of last exposure: _____

☐ Unknown

Was this an occupational/volunteer exposure?

☐ Yes ☐ No ☐ Unknown

[If yes] Specify the occupation: _____

Is the setting of the exposure the same as the HAB event reported?

☐ Yes ☐ No ☐ Unknown

EXPOSURE SOURCE

What was the source of the exposure? *(Select all that apply)*

☐ Food ☐ Water (including aerosols) ☐ Other(specify): _____ ☐ Unknown

[If food] FOOD EXPOSURES

What was the food exposure? *(Select all that apply)*

☐ Fish (specify): _____

☐ Other (e.g., supplements) (specify): _____

☐ Shellfish (specify): _____

☐ Unknown

☐ Produce (specify): _____

[If fish/shellfish] Was it commercially or non-commercially harvested?

☐ Non-commercially (self-harvested)

☐ Commercially (consumed in a regulated setting, e.g., restaurant)

☐ Unknown

WATER AND OTHER EXPOSURES

[If Water or Other] How did the exposure occur?

Direct contact with skin or eyes (e.g., swimming)

☐ Yes ☐ No ☐ Unknown

Ingestion (e.g., drinking from waterbody)

☐ Yes ☐ No ☐ Unknown

Aerosol inhalation (e.g., watersports, walking near the shore)

☐ Yes ☐ No ☐ Unknown

Other (specify): _____

☐Unknown

WATER EXPOSURE ACTIVITY

Participation in direct contact water activities or watersports (e.g., swimming, diving, snorkeling, tubing, water skiing, etc.)

☐ Yes ☐ No ☐ Unknown

Participation in indirect/limited contact water activities or watersports (e.g., boating, fishing, kayaking, canoeing, etc.)

☐ Yes ☐ No ☐ Unknown

Participation in other activities (e.g., hiking, walking, etc.)

☐ Yes ☐ No ☐ Unknown

SIGNS/SYMPTOMS OF HUMAN ILLNESS

Date of illness onset(MM/DD/YYYY):_____ ☐Unknown

Approximate time of illness onset:

☐ Early morning (12:00AM – 6:00AM)

☐ Morning (6:00AM – 12:00 PM)

☐ Afternoon (12:00PM – 6:00PM)

☐ Evening (6:00PM – 9:00PM)

☐ Night (9:00PM – 12:00AM)

☐ Unknown

Date of illness recovery (MM/DD/YYYY):_____ ☐Unknown

Approximate time of illness recovery:

☐ Early morning (12:00AM – 6:00AM)

☐ Morning (6:00AM – 12:00 PM)

☐ Afternoon (12:00PM – 6:00PM)

☐ Evening (6:00PM – 9:00PM)

☐ Night (9:00PM – 12:00AM)

☐ Unknown

Length of time between illness onset and exposure:_____

☐ ≤3 hours ☐ >3 ≤ 12 hours ☐ >12 ≤ 24 hours ☐ >24 ≤48 hours ☐ >48 hours ☐ Unknown

Was the person still experiencing signs/symptoms at the time of the interview?

☐Yes ☐ No ☐ Unknown

Commonly Reported Sign/Symptom	Yes/No/Unknown
Rash/itchy skin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Abdominal cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Malaise (general discomfort)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Other signs/symptoms (Select all that apply): _____

Did any symptoms reoccur after multiple exposures?

☐Yes ☐ No ☐ Unknown

[If fish or shellfish] Were the signs/symptoms consistent with fish/shellfish poisoning?

☐Yes ☐ No ☐ Unknown

[If yes] Poisoning description (e.g., Ciguatera Fish Poisoning):_____

MEDICAL INFORMATION

HEALTHCARE SEEKING BEHAVIOR

Did the person receive first aid care from a non-medical provider? (e.g., park staff)

☐Yes ☐ No ☐ Unknown

Did the person visit a healthcare provider? (e.g., non-emergency, urgent care)

☐Yes ☐ No ☐ Unknown

Did the person go to an emergency department?

☐Yes ☐ No ☐ Unknown

Was a Poison Control Center contacted?

☐Yes ☐ No ☐ Unknown

HEALTH OUTCOMES

Was the person hospitalized?

☐Yes ☐ No ☐ Unknown

[If yes] How many days was the person hospitalized? _____

Did the person die?

☐Yes ☐ No ☐ Unknown

[If yes] Date of death (MM/DD/YYYY):_____

HEALTH INDICATORS

At the time of exposure did the person have any of the following health indicators?

Is this person considered immunocompromised?

☐ Yes ☐ No ☐ Unknown

Chronic respiratory disease (e.g. asthma, COPD)

☐ Yes ☐ No ☐ Unknown

Chronic skin disease (e.g. psoriasis, eczema)

☐ Yes ☐ No ☐ Unknown

Chronic gastrointestinal disease (e.g. Crohn's disease)

☐ Yes ☐ No ☐ Unknown

Other chronic disease? _____

Was the person pregnant at the time of exposure?

☐ Yes ☐ No ☐ Unknown

DIFFERENTIAL DIAGNOSIS AND CLINICAL TESTING

At the time of exposure, was the person taking medication that increased skin sensitivity to the sun (e.g., acne treatment, antibiotics)?

☐ Yes ☐ No ☐ Unknown

At the time of exposure, did the person have an open wound, sores, or broken skin?

☐ Yes ☐ No ☐ Unknown

Were other causes of illnesses investigated and ruled out?

☐ Yes ☐ No ☐ Unknown

HUMAN LABORATORY TESTING

Were clinical specimens tested?

☐ Yes ☐ No ☐ Unknown

[If yes] What type(s) of clinical testing were done to diagnose the illness or rule out other causes? *(Select all that apply)*

☐ Bloodwork

☐ Imaging (e.g., x-ray, ultrasound, etc.)

☐ Fecal analysis

☐ None

☐ Toxicological Analysis

☐ Other (specify) _____

☐ Urinalysis

☐ Unknown

HUMAN TESTING RESULTS

In the below table, please report any laboratory results of clinical specimens that were tested for algal/cyanobacterial toxins or species—more extensive results may be attached to this report)

Clinical Specimen Number	1	2	3
Result Detected?			
Sample Collection Date (MM/DD/YYYY)			
Specimen Type (e.g., blood)			
Classification (e.g., Cyanobacteria)			
Genus or toxin (e.g., <i>Microcystis</i>)			
Species (e.g., <i>aeruginosa</i>)			
Concentration (e.g., 20)			
Unit (e.g., ppm)			
Test type (e.g., ELISA)			

HUMAN TESTING RESULTS REMARKS (Remarks should NOT include PII, CCI, other identifiers, webpage links, or additional location information.

Remarks should ONLY include information about the sample, test results, if whole blood what color tube top, or other relevant laboratory information.): _____

GENERAL REMARKS (Remarks should NOT include any PII, CCI, other identifiers, webpage links, or lab/sample/testing information. Remarks should only include relevant information not captured in the form.): _____