



SAMPLE SHORT DATA COLLECTION FORM

(FOR INVESTIGATOR'S USE)

Today's Date (month, day, year) ____/____/____ Initials of person completing form: _____
Location (state/city) of outbreak _____

PATIENT INTERVIEW

CASE ID: _____

1. Patient identifying information

Name _____
Last First Middle Initial

Date of Birth: _____
Month Day Year

Sex: Male Female Age: ____ yr ____ mo Race: White Black Asian/Pacific Islander Unknown Other _____

Hispanic or Latino: Yes No Unknown

Facility: (If hospitalized) Name _____ Present Address: Facility Name (if applicable) _____
City _____ Street _____
County _____ City _____
State _____ Phone number _____ County _____ State _____
Medical Record #: _____

2. Symptoms, Signs and Significant Conditions

Date of symptom onset: _____ Date of first presentation for medical care: _____
Month Day Year Month Day Year

Does the patient have:

Fever (subjective)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Nasal congestion	<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	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, productive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Blood in sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Wheeze	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chills/Rigors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Runny nose	<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
Sore throat	<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
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Stiff neck	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Red or draining eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sneezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Weight loss over past 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

3. Exposure History

Do you know of others who have been ill with similar symptoms? Yes No Unknown

If yes, describe symptoms, time period of symptoms, and relationship to this patient: _____

Has the patient been exposed to any animals/insect bites in the last 10 days? Yes No Unknown

If yes, describe _____

Has the patient been traveling (overnight or day trip) in the last two weeks?: Yes No Unknown

If yes, describe _____

4. General Notes/Comments

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CHART REVIEW/CLINICAL DATA

5. Clinical Data

Did the person have:

- | | | | | | | | |
|---------------------------------------|------------------------------|-----------------------------|----------------------------------|--------------------------------|------------------------------|-----------------------------|----------------------------------|
| Temp ≥ 38.0 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Crackles/Rhonchi | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Adult Respiratory rate (RR) ≥ 25 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Hypotension | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Child <5 years: RR ≥ 40 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Cyanosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Infant: RR ≥ 50 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Altered mental status | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| If age < 5 years: | | | | Meningismus or nuchal rigidity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Lower chest indrawing | <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 |
| Pulse Ox $\leq 95\%$ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Wheeze | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Lymphadenopathy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| | | | | Poor feeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

Past Medical History (Check all that apply):

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Current smoker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis (if yes, <input type="checkbox"/> Latent <input type="checkbox"/> Active) | <input type="checkbox"/> IV drug use | _____ |

6. Treatment

Was the patient:

- Admitted to hospital Yes No Unknown
- If yes, date admitted:

Month	Day	Year			

Outcome:

- Still hospitalized? Yes No Unknown
- Discharged? Yes No Unknown
- Died? Yes No Unknown

- Admitted to ICU Yes No Unknown

Required:

- | | |
|--|---|
| Supplemental oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Received antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Mechanical ventilation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | If yes, antibiotic(s): _____ |
| | Received antivirals? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| | If yes, antiviral(s): _____ |

7. Laboratory Testing

Specimens collected and test requested:

- | | | |
|--|---|--|
| Sputum: <input type="checkbox"/> Gram stain/Culture | Swabs: <input type="checkbox"/> Nasopharyngeal | Blood: <input type="checkbox"/> Culture |
| <input type="checkbox"/> AFB | <input type="checkbox"/> Nasal-Pertussis (special media required) | <input type="checkbox"/> Serology |
| <input type="checkbox"/> Fungal stain or culture | <input type="checkbox"/> Oropharyngeal | If yes: <input type="checkbox"/> acute |
| | | <input type="checkbox"/> convalescent |
| Urine: <input type="checkbox"/> Legionella antigen | Fluid: <input type="checkbox"/> Bronchoalveolar Lavage | Other: _____ |
| <input type="checkbox"/> Pneumococcal antigen | <input type="checkbox"/> Pleural | _____ |
| <input type="checkbox"/> Histoplasma antigen | | |

8. Laboratory Results

Type of Specimen	Date of Collection	Tests Performed	Results

9. Radiological Testing

- Was a chest X-ray or chest CT scan performed? Yes No Unknown
- If yes, check all that apply:
- | | |
|--|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Cavitary lesion or blebs |
| <input type="checkbox"/> Lobar consolidation or dense infiltrate | <input type="checkbox"/> Interstitial infiltrate |
| <input type="checkbox"/> Pleural effusion | <input type="checkbox"/> Other _____ |