

Measles

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____

Referred to another state: _____

CASE

Last name: _____
First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Gender: Female Male Other _____

Maiden name: _____ Suffix: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Address line: _____

Marital status: Single Married Divorced Parent with partner Separated Widowed

Zip: _____ City: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

State: _____ County: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Phone: (____) - ____ - ____ Type: _____

Long-term care resident: Yes No Unknown

Parent/Guardian name: _____

Facility name: _____

Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____

Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown

Outbreak related: Yes No Unknown

Outbreak name: _____

Exposure setting: _____

Epi-linked: Yes No Unk To whom: _____

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

State: _____ Country: _____

Healthcare provider information

Last name: _____

First name: _____

Provider title: ARNP MD DO NP PA

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone : (____) - ____ - ____ Type: _____

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: Measles virus

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: Measles virus

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Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Confidential

PATIENT NAME: _____

Iowa Department of Public Health

Organism: Measles virus

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Symptoms	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____	Duration: _____ hrs/days	Highest known fever: _____ °F/C
	Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____	Other symptoms	<input type="checkbox"/> Abdominal cramps
	Runny nose <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____		<input type="checkbox"/> Backache
	Red eyes w/t drainage <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____		<input type="checkbox"/> Chills
	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____		<input type="checkbox"/> Encephalitis
	Thrombocytopenia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____		<input type="checkbox"/> Fatigue
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____	<input type="checkbox"/> Sore throat		<input type="checkbox"/> Headache
Other complications: _____	Describe: _____	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Joint pain	
	Date returned to normal activities: ____ / ____ / ____		<input type="checkbox"/> Muscle pain	
Rash: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____ / ____ / ____	Duration: _____ hours/days	<input type="checkbox"/> Nausea	
Fever continued w/t rash: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash spreading: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<input type="checkbox"/> Otitis media	
Rash equally distributed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash appeared at once: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<input type="checkbox"/> Photophobia	
Lesions present: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash initial location: <input type="checkbox"/> Arms <input type="checkbox"/> Face <input type="checkbox"/> Legs <input type="checkbox"/> Trunk		<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Inside mouth			

Avg size of non-infected lesion: _____ in/cm

of days for first lesion to crust: _____ days

Lesions in same stage of development: Yes No Unk

Rash characteristics: Burning
 Confluent lesions
 Could be felt (papule)
 Could not be felt (macule)

Heaviest lesion area: Arms Face Legs Trunk Scalp

Areas present: Inside mouth Palms Soles

Severity: < 50 lesions 250 – 500 lesions
 50 – 249 lesions > 500 lesions

Discrete lesions Numbness
 Distinct sharp borders Painful
 Dusky brown Peeling skin
 Marked itching Pustule

Koplik's spots: Yes No Unk

Healthcare provider visited: Yes No Unk

Date(s) visited: _____ / _____ / _____, _____ / _____ / _____, _____ / _____ / _____

Swollen lymph nodes: Yes No Unk

Location: _____

TREATMENT

Antivirals prescribed: Yes No Unknown

Antiviral: _____
 Date started: _____ / _____ / _____
 Dose: _____
 Unit: mg ml IU # of days: _____
 # of times a day: _____ Route: _____

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 Date started: _____ / _____ / _____
 Dose: _____
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 # of times a day: _____ Route: _____

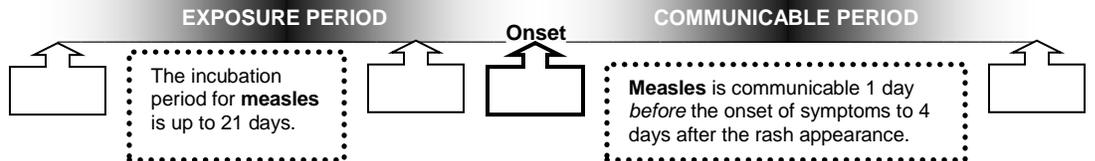
Antiviral: _____
 Date started: _____ / _____ / _____
 Dose: _____
 Unit: mg ml IU # of days: _____
 # of times a day: _____ Route: _____

Therapeutic medications prescribed? Yes No Unk

List medications: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Vaccinated with MMR: Yes No Unknown

Date vaccinated: _____ / _____ / _____
 Lot #: _____
 Vaccine type: _____
 Manufacturer: _____

Date vaccinated: _____ / _____ / _____
 Lot #: _____
 Vaccine type: _____
 Manufacturer: _____

Date vaccinated: _____ / _____ / _____
 Lot #: _____
 Vaccine type: _____
 Manufacturer: _____

Number of vaccinations: _____

In the 21 days prior to the onset of symptoms did the case:

Traveled within Iowa? Yes No Unk City in Iowa: _____ Departure date: _____ / _____ / _____ Return date: _____ / _____ / _____

Traveled within U.S.? Yes No Unk State: _____ City: _____ Departure date: _____ / _____ / _____ Return date: _____ / _____ / _____

Traveled outside U.S.? Yes No Unk Country: _____ Departure date: _____ / _____ / _____ Return date: _____ / _____ / _____

Born outside the U.S.? Yes No Unknown Country outside the U.S.: _____

Immunocompromised? Yes No Unknown

In the 1 day prior to the onset of rash through 4 days after the onset of rash did the case:

Use public transportation: Yes No Unk

Date(s) used:	Time(s) used:	Type:	Route:
/ /			
/ /			
/ /			

Visit a doctor's office, clinic or hospitals: Yes No Unknown

If Yes, complete the following table:

Facility name: _____	Facility name: _____
Address: _____	Address: _____
Zip code: _____ City: _____	Zip code: _____ City: _____
State: _____ County: _____	State: _____ County: _____
Phone: ()- - Type: _____	Phone: ()- - Type: _____
Date visited: / / Time visited: _____	Date visited: / / Time visited: _____
Provider name: _____ Title: _____	Provider name: _____ Title: _____

Visit a public places: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Phone	Date(s) visited	Time visited
		()- -	/ /	
		()- -	/ /	
		()- -	/ /	

Attend religious gatherings: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Attend family gatherings: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Attend other gatherings: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Setting Acquired:

Child care <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Home <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Church <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	International traveler <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	School <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
College <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Military <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Urgent care <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Correctional Facility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospital ER/Outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Doctors office <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

