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: Maiden name: Suffix: Address line: Zip: City: State: County: Phone: ( )- - Type: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian 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

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

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: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms

Fever ☐ Yes ☐ No ☐ Unk Onset date: / / Duration: hrs/days Highest known fever: °F/C

Cough ☐ Yes ☐ No ☐ Unk Onset date: / /

Runny nose ☐ Yes ☐ No ☐ Unk Onset date: / /

Red eyes w/t drainage ☐ Yes ☐ No ☐ Unk Onset date: / /

Diarrhea ☐ Yes ☐ No ☐ Unk Onset date: / /

Thrombocytopenia ☐ Yes ☐ No ☐ Unk Onset date: / /

Arthritis ☐ Yes ☐ No ☐ Unk Onset date: / /

Other complications: Describe:

Other symptoms

☐ Abdominal cramps ☐ Backache ☐ Chills ☐ Encephalitis ☐ Fatigue ☐ Sore throat ☐ Vomiting

☐ Headache ☐ Joint pain ☐ Muscle pain ☐ Nausea ☐ Otitis media ☐ Photophobia ☐ Pneumonia

Date returned to normal activities: / /

Rash: ☐ Yes ☐ No ☐ Unk Onset date: / / Duration: hours/days

Fever continued w/t rash: ☐ Yes ☐ No ☐ Unk

Rash spreading: ☐ Yes ☐ No ☐ Unk

Rash equally distributed: ☐ Yes ☐ No ☐ Unk

Rash appeared at once: ☐ Yes ☐ No ☐ Unk

Lesions present: ☐ Yes ☐ No ☐ Unk

Rash initial location: ☐ Arms ☐ Face ☐ Legs ☐ Trunk ☐ 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)
☐ Discrete lesions
☐ Distinct sharp borders
☐ Dusky brown
☐ Marked itching
☐ Numbness
☐ Painful
☐ Peeling skin
☐ Pustule
☐ Reddish
☐ Scaling/crusting

Koplik's spots: ☐ Yes ☐ No ☐ Unk

Healthcare provider visited: ☐ Yes ☐ No ☐ Unk

Swollen lymph nodes: ☐ Yes ☐ No ☐ Unk

Heaviest lesion area: ☐ Arms ☐ Face ☐ Legs ☐ Trunk ☐ Scalp

Areas present: ☐ Inside mouth ☐ Palms ☐ Soles

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

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

Location:

TREATMENT

Antivirals prescribed: ☐ Yes ☐ No ☐ Unknown

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

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

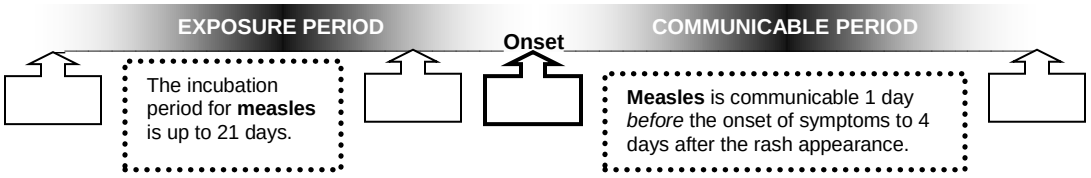
Antiviral: _____
Date started: / /
Dose: _____
Unit: ☐ mg ☐ ml ☐ IU
# of days: _____
# of times a day: _____
Route: _____

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

Facility name: _____ Address: _____ Zip code: _____ City: _____ State: _____ County: _____ Phone: ( )- - Type: _____ Date visited: / / Time visited: _____ 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	☐ Yes ☐ No ☐ Unk	Hospitalized	☐ Yes ☐ No ☐ Unk	Home	☐ Yes ☐ No ☐ Unk
Church	☐ Yes ☐ No ☐ Unk	International traveler	☐ Yes ☐ No ☐ Unk	School	☐ Yes ☐ No ☐ Unk
College	☐ Yes ☐ No ☐ Unk	Military	☐ Yes ☐ No ☐ Unk	Urgent care	☐ Yes ☐ No ☐ Unk
Correctional Facility	☐ Yes ☐ No ☐ Unk	Hospital ER/ Outpatient	☐ Yes ☐ No ☐ Unk	Work	☐ Yes ☐ No ☐ Unk
Doctors office	☐ Yes ☐ No ☐ Unk			Other	

Disease traced within 2 generations of known international import? ☐ Yes ☐ No ☐ Unk

CONTACTS

Number of people living in case's household: ____

Close contacts of the case (For more than one contact, print/copy additional contact pages.)

Last name: _____ Address: _____

First name: _____ City/State/Zip: _____ County: _____

DOB: / / Age: _____ Phone: _____ Type: _____

Gender: ☐ Female ☐ Male ☐ Other Symptoms present: ☐ Yes ☐ No ☐ Unk Onset date: / /

If this contact has an onset date before this case then create a new case and event.

Symptoms:

Fever ☐	Onset date: / /	Fatigue ☐	
Cough ☐	Onset date: / /	Headache ☐	
Runny nose ☐	Onset date: / /	Muscle pain ☐	
Red eyes w/t discharge ☐	Onset date: / /	Nausea ☐	
Rash ☐	Onset date: / /	Otitis media ☐	
Abdominal cramps ☐		Photophobia ☐	
Backache ☐		Pneumonia ☐	
Chills ☐		Sore throat ☐	
Encephalitis ☐		Vomiting ☐	

Same travel location(s): ☐ Yes ☐ No ☐ Unk

Worked with case: ☐ Yes ☐ No ☐ Unk

From date: / /

To date: / /

Similar exposure setting: ☐ Yes ☐ No ☐ Unk

Contact exposure setting: ☐ Doctor's office ☐ Family gathering ☐ Group meeting ☐ Public transportation ☐ Religious activity

Vaccinated for Measles (MMR): ☐ Yes ☐ No ☐ Unk Number of vaccinations: Received within 3 days: ☐ Yes ☐ No ☐ Unk

Exposed to Measles: ☐ Yes ☐ No ☐ Unk Received IG within 6 days: ☐ Yes ☐ No ☐ Unk Date received: / / Dose: Unit: Route:

Tested for immunity: ☐ Yes ☐ No ☐ Unk Result: ☐ IgM+ ☐ IgM- ☐ IgG+ ☐ IgG-

Vaccinated for Smallpox: ☐ Yes ☐ No ☐ Unk Exposed to Smallpox: ☐ Yes ☐ No ☐ Unk Number of vaccinations: Received within 4 days: ☐ Yes ☐ No ☐ Unk

Vaccinated for Rubella: ☐ Yes ☐ No ☐ Unk Exposed to Rubella: ☐ Yes ☐ No ☐ Unk Number of vaccinations: Tested for immunity: ☐ Yes ☐ No ☐ Unk Result: ☐ IgM+ ☐ IgM- ☐ IgG+ ☐ IgG-

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

NOTES: _____

PROPHYLAXIS

Name	DOB	Exposed to case	Vaccinated for measles	Number of doses	Dates of vaccination	Received MMR due to this exposure	Received IG due to this exposure	Notes
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
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