Mumps

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

Was an influenza test done? ☐ Yes ☐ No ☐ Unknown
If yes, what was the result?

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Mumps virus*** Type (e.g. serotype):

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Mumps virus*** Type (e.g. serotype):

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

Classic symptoms

Swelling OR pain of parotid gland: ☐ Yes ☐ No ☐ Unk
Swelling OR pain of sublingual or submandibular (submaxillary) glands: ☐ Yes ☐ No ☐ Unk
Did the glandular swelling or pain last at least 2 days: ☐ Yes ☐ No ☐ Unk

Other symptoms

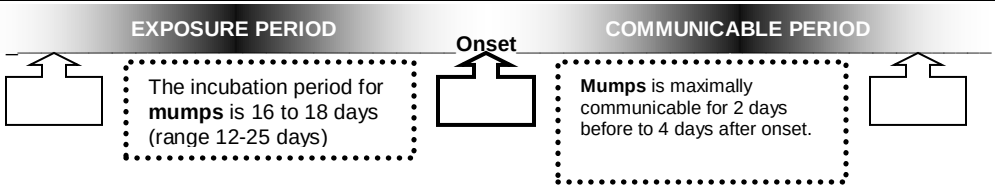
☐ Fever ☐ Parotitis ☐ Oophritis
☐ Orchitis ☐ Swollen lymph nodes ☐ Other symptoms:

Complications

☐ Aseptic meningitis ☐ Encephalitis ☐ Mastitis
☐ Deafness ☐ Hearing loss ☐ Pancreatitis ☐ Other complications:

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

If pregnant during illness, how many weeks gestation was case at time of onset: _____

Vaccinated for mumps: ☐ Yes ☐ No ☐ Unknown

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

Number of vaccinations: _____

If not vaccinated, reason: ☐ Lab evidence of previous disease ☐ Religious exemption ☐ Other ☐ Medical contraindication ☐ Under age 12 months ☐ Unknown ☐ Parental refusal

Transmission setting: ☐ Day care ☐ School ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient clinic ☐ Home ☐ Work ☐ Unknown ☐ College ☐ Military ☐ Correctional facility ☐ Church ☐ International travel ☐ Other

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

Risk Factors/Travel Information – *In the 25 days prior to onset of symptoms had 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: / /

CONTACTS

Contacts with the same symptoms: ☐ Yes ☐ No ☐ Unknown

Contacts with the same symptoms

Name

First name Last name

Relationship to case (Reminder: each contact must be entered as a new case in IDSS and interviewed)

☐ Family member (household)
☐ Family member (non-household)
☐ Roommate
☐ Sexual contact/significant other
☐ Friend/acquaintance
☐ Contact- work/school/etc.

Symptom onset date / /

NOTES: