Smallpox

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: Variola virus

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

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

Organism: Variola 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 symptoms

☐ Abdominal cramps
☐ Backache
☐ Chills
☐ Encephalitis
☐ Fatigue
☐ Fever
☐ Sore throat
☐ Vomiting
☐ Headache
☐ Joint pain
☐ Muscle pain
☐ Nausea
☐ Otitis media
☐ Photophobia

Other complications: [CA1] Describe:
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 lesions: ____ 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

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

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

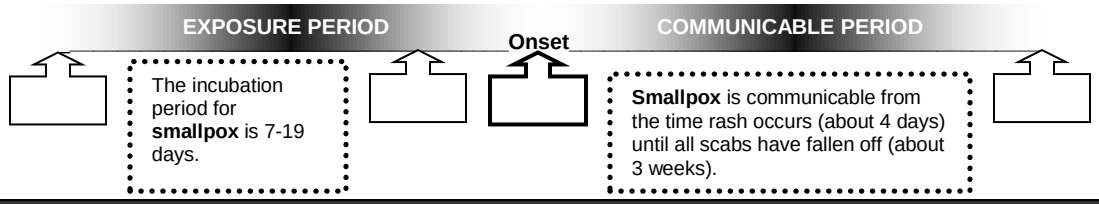
Antiviral:	Antiviral:	Antiviral:
Date started: __/__/__	Date started: __/__/__	Date started: __/__/__
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of days:	# of days:	# of days:
# of times a day:	# of times a day:	# of times a day:
Route:	Route:	Route:

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 for smallpox: ☐ Yes ☐ No ☐ Unknown

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

Number of vaccinations: ____

In the 19 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 4 days after the onset of rash until about 3 weeks after the rash started:

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	☐ 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: _____