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 _____
City _____
County _____
State _____ Phone number_____
Medical Record #:_____

Present Address:
Facility Name (if applicable) _____
Street_____
City _____
County _____ State _____

2. Symptoms, Signs and Significant Conditions

Date of symptom onset: Month Day Year

Date of first presentation for medical care: Month Day Year

Does the patient have:

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

_____

_____

_____

CHART REVIEW/CLINICAL DATA

5. Clinical Data

Did the person have:

Temp ≥38.0	☐ Yes	☐ No	☐ Unknown	Crackles/Rhonchi	☐ Yes	☐ No	☐ Unknown
Adult Respiratory rate (RR) ≥25	☐ Yes	☐ No	☐ Unknown	Hypotension	☐ Yes	☐ No	☐ Unknown
Child <5 years: RR ≥ 40	☐ Yes	☐ No	☐ Unknown	Cyanosis	☐ Yes	☐ No	☐ Unknown
Infant: RR ≥ 50	☐ Yes	☐ No	☐ Unknown	Altered mental status	☐ Yes	☐ No	☐ Unknown
If age < 5 years:				Meningismus or nuchal rigidity	☐ Yes	☐ No	☐ Unknown
Lower chest indrawing	☐ Yes	☐ No	☐ Unknown	Headache	☐ Yes	☐ No	☐ Unknown
Pulse Ox ≤95%	☐ Yes	☐ No	☐ Unknown	Rash	☐ Yes	☐ No	☐ Unknown
Wheeze	☐ Yes	☐ No	☐ Unknown	Lymphadenopathy	☐ Yes	☐ No	☐ Unknown
				Poor feeding	☐ Yes	☐ No	☐ Unknown

Past Medical History (Check all that apply):

☐ Immunocompromised ☐ Congestive heart failure ☐ Current smoker ☐ Other _____
☐ COPD ☐ Diabetes ☐ Asthma _____
☐ HIV/AIDS ☐ Tuberculosis (if yes, ☐ Latent ☐ Active) ☐ IV drug use _____

6. Treatment

Was the patient:

Admitted to hospital ☐ Yes ☐ No ☐ Unknown
If yes, date admitted: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Admitted to ICU ☐ Yes ☐ No ☐ Unknown

Required:

Supplemental oxygen ☐ Yes ☐ No ☐ Unknown
Mechanical ventilation ☐ Yes ☐ No ☐ Unknown

Outcome:

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

Received antibiotics? ☐ Yes ☐ No ☐ Unknown
If yes, antibiotic(s):_____
Received antivirals? ☐ Yes ☐ No ☐ Unknown
If yes, antiviral(s):_____

7. Laboratory Testing

Specimens collected and test requested:

Sputum: ☐ Gram stain/Culture ☐ AFB ☐ Fungal stain or culture

Swabs: ☐ Nasopharyngeal ☐ Nasal-Pertussis (special media required) ☐ Oropharyngeal

Blood: ☐ Culture ☐ Serology
If yes: ☐ acute ☐ convalescent

Urine: ☐ Legionella antigen ☐ Pneumococcal antigen ☐ Histoplasma antigen

Fluid: ☐ Bronchoalveolar Lavage ☐ Pleural

Other: _____
_____

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: ☐ Normal ☐ Lobar consolidation or dense infiltrate ☐ Pleural effusion ☐ Cavitary lesion or blebs ☐ Interstitial infiltrate ☐ Other _____