

CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Demographic data:

Patient's name (first 4 letters of last name): ___ ___ ___ ___ **Sex:** ___ Male ___ Female
State of residence: _____ **County:** _____ **Age:** ___ **Date of birth** (mm/yyyy): ___/___/___
Ethnic origin: _____ **Race** (check all that apply):
___ Hispanic or Latino _____ White _____ American Indian or Alaska Native
___ Not Hispanic or Latino _____ Black or African American _____ Native Hawaiian or other Pacific Islander
___ Unknown _____ Asian _____ Unknown

Physician's name: _____
Phone: ___-___-___-___ **FAX:** ___-___-___-___ **Email:** _____

Clinical data: (For dates, be as specific as possible. However, approximations [e.g., mm/yy] are okay.)

Date of onset of illness / symptoms (mm/dd/yy): ___/___/___ (___ Unknown date; unable to approximate)

Signs and symptoms: Diarrhea: ___ Yes ___ No ___ Unknown If yes, maximum number stools per day: _____ (unknown = 999) Weight loss: ___ Yes ___ No ___ Unknown If yes, baseline weight: _____ lbs. (unknown = 999) Number of pounds lost: _____ Fever (or felt feverish): ___ Yes ___ No ___ Unknown If yes, temperature: _____ degrees F (unknown or not measured = 999) Other symptoms (specify): _____	Fatigue: ___ Yes ___ No ___ Unknown Anorexia: ___ Yes ___ No ___ Unknown Nausea: ___ Yes ___ No ___ Unknown Vomiting: ___ Yes ___ No ___ Unknown Abdominal cramps: ___ Yes ___ No ___ Unknown
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Hospitalized (at least overnight): ___ Yes ___ No ___ Unknown
If yes, name of hospital: _____ Date of admission: ___/___/___

Date stool collected for Cyclospora testing: ___/___/___ (If multiple stools, specify below or on p. 2.) Test results: ___ Positive ___ Negative ___ Unknown (or pending) If known, specify testing methods and laboratories, including, if applicable, testing done by state or CDC labs: _____ Results from state lab (not applicable: ___): ___ Positive ___ Negative ___ Unknown (or pending) Results from CDC lab (not applicable: ___): ___ Positive ___ Negative ___ Unknown (or pending)

Has the case-patient been treated (or is he/she being treated) for cyclosporiasis? ___ Yes ___ No ___ Unknown
If yes, what medication(s)? ___ Trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)
___ Other (specify): _____
___ Unknown

Is case-patient allergic to (or intolerant of) sulfa drugs? ___ Yes ___ No ___ Unknown

Exposures during 2 weeks before onset of illness:

(For dates, be as specific as possible. However, approximations [e.g., mm/yy] are okay.)

History of travel (during 2 weeks before onset of illness): Yes No Unknown

International travel (country): (**Unknown dates of travel and unable to approximate**)

(1) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(2) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(3) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

U.S. travel (state): (**Unknown dates of travel and unable to approximate**)

(1) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(2) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(3) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

Fresh produce exposures (produce eaten or tasted during 2 weeks before onset of illness):

Fresh berries: Yes (if yes, specify types; check all that apply) No Unknown

Strawberries Blackberries Blueberries

Raspberries Black raspberries Golden raspberries Unknown type of berry

Other types of berries (specify): _____

Fresh herbs: Yes (if yes, specify types; check all that apply) No Unknown

Cilantro Oregano Thyme Mint Dill Parsley Rosemary

Basil (specify types): Sweet basil Thai basil (i.e., green leaves and purple stems)

Purple basil (i.e., purple leaves and stems)

Other types of herbs (specify): _____

Unknown type of herb

Lettuce: Yes (if yes, specify types; check all that apply) No Unknown

Mesclun (a.k.a., spring mix, field greens, baby greens, & gourmet salad mix)

Arugula

Other types of lettuce (specify): _____

Unknown type of lettuce

Other types of fresh produce: Yes (if yes, specify types; check all that apply) No Unknown

Fruit, other than berries (specify types): _____

Snow peas (flat, shiny pea pods containing tiny peas)

Other types of fresh produce (specify): _____

Unknown type of fresh produce

Did the case-patient attend any events (e.g., wedding reception) (during 2 weeks before onset of illness)?

Yes No Unknown

If yes, specify type of social or other event: _____ Event date: ___/___/___

Does the case-patient know of other ill persons? Yes No Unknown

If yes, did health department obtain contact information and investigate further (provide comments below)?

Yes No Under consideration (or pending) Unknown

Comments and additional data:

Name (person filling out form): _____ **Title:** _____

Phone: _____ - _____ - _____ **FAX:** _____ - _____ - _____ **Email:** _____

Name of investigating health department: _____ **Date form submitted:** ___/___/___