Kansas Department of Health and Environment
Epidemiology and Public Health Informatics

Amebiasis Report Form

INTERVIEW

EpiTrax # _____ Interviewer Name:_____

Number of Call Attempts:_____ Date of Interview (must enter MM/DD/YYYY): _____

Interview Start Time: _____ Interview End Time: _____

Follow-up Status:
- ☐ Interviewed
- ☐ Refused Interview
- ☐ Lost to Follow-Up*

Respondent was:
- ☐ Self
- ☐ Parent
- ☐ Spouse
- ☐ Other, *Specify:*_____

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

DEMOGRAPHICS

Birth Gender:
- ☐ Male
- ☐ Female

Date of Birth: _____

Age: _____

Hispanic/Latino Origin:
- ☐Yes
- ☐No
- ☐Unknown

How would you describe your race?
- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other_____
- ☐ Unknown

CLINICAL

Did you have any symptoms?
- ☐Yes
- ☐ No
- ☐ Unknown

If yes, turn to page 3 and record specific symptoms under Investigation.

What date did you start to have symptoms of illness? Onset Date:_____ Onset Time:_____

Calculate Amebiasis exposure time frame **30 days** before onset

Do not read to patient; however, use the information to assess exposure.

Exposure period: _____

Did you recover? ☐ Yes ☐ No ☐ Unknown

Were you hospitalized? ☐ Yes ☐ No ☐ Unknown

If Yes, Recovery Date: _____

If Yes, Hospital Name:_____

Time Recovered:_____.

Admit date: _____ Discharge Date: _____

Died?

☐Yes ☐No ☐Unknown

If Yes, Date of Death:_____

Are you pregnant?

☐Yes ☐No ☐Unknown

If Yes, Expected Delivery Date:

Did you receive antimicrobial medication for this illness? ☐Yes ☐ No ☐ Unknown

Medication Name	Date Started	Date Ended

Additional Clinical Notes:

_____

_____

_____

_____

EPIDEMIOLOGICAL

Occupation:_____+

Check all that apply: ☐ Volunteer ☐ Unemployed ☐ Retired

Is this patient a:

Food handler?	☐ Yes ☐ No ☐ Unknown
Health care worker?	☐ Yes ☐ No ☐ Unknown
Group living?	☐ Yes ☐ No ☐ Unknown
Day care attendee?	☐ Yes ☐ No ☐ Unknown
Day care worker?	☐ Yes ☐ No ☐ Unknown
School attendee?	☐ Yes ☐ No ☐ Unknown
School employee?	☐ Yes ☐ No ☐ Unknown

If yes to any, list details for each:

Facility Name(s):	
Address(es):	
Phone Number(s):	

If Yes to any above, did you work or attend while ill? ☐ Yes ☐ No ☐ Unknown

If Yes, Dates Worked or Attended/Notes:

_____

_____

INVESTIGATION

A. Clinical Symptoms

Reasons for testing* ☐ Symptomatic ☐ Refugee Screening ☐ International Adoption

*If refugee or international adoption, what is the country of origin?_____

Date arrived in U.S. _____

Diarrhea?	☐Yes ☐ No ☐ Unknown	If yes, maximum # of stools/24 hours ____
Bloody Diarrhea?	☐Yes ☐ No ☐ Unknown	
Vomiting?	☐Yes ☐ No ☐ Unknown	
Abdominal Cramps or Pain?	☐Yes ☐ No ☐ Unknown	
Nausea?	☐Yes ☐ No ☐ Unknown	
Loss of Appetite?	☐Yes ☐ No ☐ Unknown	
Weight Loss?	☐Yes ☐ No ☐ Unknown	
Fever?	☐Yes ☐ No ☐ Unknown	If yes, highest measured temperature (°F) ____
Other Symptoms?	☐Yes ☐ No ☐ Unknown	If yes, specify: _____

B. Water Exposure

In the 30 days before illness, what was your source of drinking water:

At Home?
- ☐ Municipal
- ☐ Well
- ☐ Bottle
- ☐ Commercial Delivery
- ☐ Other

If other, specify _____

At Work/School?
- ☐ Municipal
- ☐ Well
- ☐ Bottle
- ☐ Commercial Delivery
- ☐ Other

If other, specify _____

Recent plumbing/construction work done on water system at home? ☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

Did you swim or wade in any recreational water in the 30 days **before** onset of symptoms? ☐ Yes ☐ No ☐ Unknown

If yes to the above question, please provide additional information below:

Kiddie/Inflatable	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Public/City pool	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Hot tub/Spa/Jacuzzi	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Water park	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Splash pad/Park	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Hotel/Motel pool or spa	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____

Fountain/Interactive water feature	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Irrigation/Canal water	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Sprinklers	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Any natural water (lake, river, reservoir, pond, stream, ocean or hot spring)	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Other recreational water	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____

Did you drink or accidentally ingest any untreated water (e.g., pond, stream, spring, river or lake)? ☐ Yes ☐ No ☐ Unknown

If yes, please source(s) of untreated water, location(s) of untreated water and date(s) of exposure:_____

_____

_____

Did you participate in other water activities such as fishing, kayaking, canoeing, or other boating? ☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

Did you have exposure to recreational water **after** onset of illness? ☐ Yes ☐ No ☐ Unknown

If yes to the above question, please provide additional information below:

Kiddie/Inflatable	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Public/City pool	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____

Hot tub/Spa/Jacuzzi	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Water park	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Splash pad/Park	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Hotel/Motel pool or spa	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Fountain/Interactive water feature	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Irrigation/Canal water	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Sprinklers	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Any natural water (lake, river, reservoir, pond, stream, ocean or hot spring)	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____
Other recreational water	☐ Yes ☐ No	Location/Date 1._____ 2._____ 3._____

C. Other Exposure—Risk Factors

In the 30 days prior to onset of illness, did the patient:

Have any sexual partner ill with similar symptoms? ☐ Yes ☐ No ☐ Unknown

Receive any colonics? ☐ Yes ☐ No ☐ Unknown

Have contact with anyone who had similar symptoms or was diagnosed with amebiasis? ☐ Yes ☐ No ☐ Unknown

If yes, list contact, with relationship to case, age, onset date, and predominant symptoms. This information will be reported under "Contacts" in EpiTrax:

Contact Name	***Relationship***	***Age***	***Onset Date***	***Predominant Symptoms***

Other Exposure—Travel History

Did you travel outside of the USA in the 25 days prior to onset of illness? ☐ Yes ☐ No ☐ Unknown

Location traveled to (i.e., City/Country Resort Information) and Dates traveled: _____

_____

_____

Traveled outside of Kansas, but inside USA? ☐ Yes ☐ No ☐ Unknown

Location traveled to (i.e., City and State Hotel Information) and Dates traveled: _____

_____

_____

Traveled outside of county, but inside Kansas? ☐ Yes ☐ No ☐ Unknown

Cities traveled to in Kansas and Dates: _____

_____

_____

Public Health Interventions (Check all that apply)

- ☐ Hygiene Education Provided
- ☐ Daycare Inspection
- ☐ Follow-up of other household member(s)
- ☐ Work or Daycare restriction for case
- ☐ Other

If other, specify: _____

That completes the interview, thank you for taking the time to answer all these questions. Your responses may be helpful in preventing others from becoming sick.

Additional notes: _____

_____

_____