

Enteric Disease Supplemental Form

Modified for Cyclosporiasis

Kansas Department of Health

Patient Demographic Information abbreviated <i>(Verify additional Demographics on General Investigation Form)</i>			
High Risk Potential: (Check all that apply) <input type="checkbox"/> Contact to a confirmed case <input type="checkbox"/> Contact to a suspected case <input type="checkbox"/> Daycare attendee <input type="checkbox"/> Food handler <input type="checkbox"/> Direct patient care worker <input type="checkbox"/> Institutional resident or staff <input type="checkbox"/> Daycare worker <input type="checkbox"/> Animal handler <input type="checkbox"/> Other			
If enrolled in day care, please complete the information below.			
Name of Facility		Evening Phone ###-###-####	
Street Address			City
County	State	Zip	
Clinical and Laboratory Data			Was a stool specimen collected? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, specify highest temperature:	Scale: <input type="checkbox"/> Fahrenheit <input type="checkbox"/> Celsius	
Diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of Stools per 24 h. <input type="checkbox"/> 0 - 2 <input type="checkbox"/> 3 - 10 <input type="checkbox"/> ≥11	Blood in Stool? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Vomiting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Nausea? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Abdominal Cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle Ache? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other Symptoms? <input type="checkbox"/> other (specify below)
Fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Anorexia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Baseline weight: _____ lbs Number lbs lost: _____ <i>Record weight loss specifics in Notes in KS-EDSS.</i>	
Was a physician consulted for this illness? <input type="checkbox"/> Yes (please complete the information below) <input type="checkbox"/> No			
Physician Information			
Name of physician:		Evening Phone ###-###-####	
Street Address			City
County	State	Zip	
Antibiotic Information			
Was case treated with antibiotics for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Type of treatment:	Date Started: mm/dd/yyyy	Date completed: mm/dd/yyyy
Was case-patient sulfa-allergic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>(report information in Notes in KS-EDSS)</i>			
Is the patient on medication or receiving any treatment which may suppress their immune system (i.e. Corticosteroids or Cancer Chemotherapy)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes please specify medication or treatment:	
Did patient recover? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Recover Date mm/dd/yyyy	Recover Time	

Exposure/Transmission

Did anyone else (in your family or household...) recently have similar symptoms?

Yes (please complete below) No Unknown

Name	Age	Sex	Relationship to Case	Occupation	Symptoms	Date of Onset
						mm/dd/yyyy

Any restaurant, commercial food establishments, or group gatherings visited within the 2 weeks prior to onset of illness?

Yes (please complete below) No Unknown

Name of Establishment	City, County, State	Foods eaten	Date of Exposure
			mm/dd/yyyy

Travel History

Did the patient Travel 2 weeks prior to the onset of illness (including international (country) and U.S. (state) travel?)

Yes No Unknown

If yes, please complete below:

Where:	Departure Date: mm/dd/yyyy	Return Date: mm/dd/yyyy
Where:	Departure Date: mm/dd/yyyy	Return Date: mm/dd/yyyy

Water Exposure

Possible water sources: (Check all that apply)

Municipal Water System Bottled Water Private Well Rural Water System Other (specify):

Did patient drink water from other than a treated municipal system (i.e., stream, well)?

Yes No Unknown

If Yes, location and date(s): (Record location and date information in Notes in KS-EDSS)

Notes:

Food History

Did case eat any of the following within 2 weeks prior to the onset of illness?

Food Product	Consumed	City, County, State	Variety or Brand(s)	Supplier	Supplier City
10. Fresh berries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Strawberries <input type="checkbox"/> Blackberries <input type="checkbox"/> Blueberries <input type="checkbox"/> Raspberries (raspb.) <input type="checkbox"/> Black raspb. <input type="checkbox"/> Golden raspb. <input type="checkbox"/> Unknown berry type <input type="checkbox"/> Other (specify):		
11. Fresh melon	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
12. Other fresh fruit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
13. Lettuce	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Mesclun (a.k.a., spring mix field greens, baby green & gourmet salad mix) <input type="checkbox"/> Arugula <input type="checkbox"/> Unknown lettuce type <input type="checkbox"/> Other (specify):		
Other: Fresh Herbs <i>(Record information under Other Food item in KS-EDSS)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Cilantro <input type="checkbox"/> Oregano <input type="checkbox"/> Thyme <input type="checkbox"/> Mint <input type="checkbox"/> Dill <input type="checkbox"/> Parsley <input type="checkbox"/> Parsley <input type="checkbox"/> Rosemary <input type="checkbox"/> Basil(specify): <input type="checkbox"/> Unknown herb type <input type="checkbox"/> Other (specify):		
Other fresh produce	Other Food Item 1		Other Food Item 2		
<p>At what store(s) do you regularly shop for groceries?</p> <p>Comments and additional data:</p>					