Dengue Report Form

INTERVIEW
EpiTrax # ________________ Interviewer Name: ____________________________________________

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

Follow-up Status: □ Interviewed Respondent was: □ Self
□ Refused Interview □ Parent
□ Lost to Follow-Up* □ 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 Hispanic/Latino Origin: How would you describe your race?
□ Female □ Yes □ White
□ Yes □ Black/African American
□ No □ American Indian/Alaska Native
□ No □ Asian
□ Unknown □ Native Hawaiian/Other Pacific Islander
□ Other: __________________
□ Unknown

Date of birth: ______________ Age: ______________

CLINICAL
Did you have any symptoms? □ Yes What date did you start to have symptoms of illness?
□ No Onset Date: __________________
□ Unknown Onset Time: __________________

Were you hospitalized? □ Yes Did the patient die? □ Yes: Date of death________
□ No □ No
□ Unknown □ Unknown

If yes, hospital name: __________________
Admit date: ______________
Discharge date: ______________

Are you pregnant? □ Yes
□ No
□ Unknown If yes, expected delivery date: __________________
LABORATORY

If serology was done, was there a fourfold change in antibody titer between the two serum specimens?
☐ Yes ☐ No

EPIDEMIOLOGICAL

Imported from:
☐ Indigenous ☐ Outside U.S. ☐ Outside of County ☐ Out of State ☐ Unknown

INVESTIGATION

A. Symptoms & Signs

Please indicate the clinical syndrome that best describes the patient’s illness:

☐ Asymptomatic
☐ Dengue Fever with hemorrhage
☐ Dengue Fever
☐ Dengue Hemorrhagic Fever/Dengue Shock Syndrome
☐ Encephalitis – including meningoencephalitis
☐ Hepatitis Jaundice
☐ Meningitis
☐ Multi-system organ failure
☐ Other clinical
☐ Uncomplicated fever
☐ Unknown

Please indicate specific symptoms:

- Fever:
  - If YES: Measured fever greater than or equal to 38°C or 100.4°F
  - If NO: Subjective Fever or Chills
  - Used over-the-counter medication that reduces fevers
  - Used treatments that suppress the immune system
  - Has an immunosuppressive condition
  - Describe immunosuppressive condition:
  - Chills or Rigors?
  - Headache?
  - Fatigue or Malaise?
  - Rash?
  - Yes ☐ No ☐ Unknown
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea or Vomiting?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Diarrhea?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Muscle weakness/pain?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Joint pains?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Arthritis?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Paresis or Paralysis?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Stiff neck?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Ataxia?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Parkinsonism or Cogwheel Rigidity?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Seizures?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Altered Mental Status?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Other symptoms?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>If yes, specify:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**B. Severe Signs and Symptoms**

*Please indicate severe signs and symptoms as determined by the patient’s physician.*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Encephalitis?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Acute flaccid paralysis?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Leukopenia?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Positive tourniquet test?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Abdominal pain or tenderness?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Clinical fluid accumulation (ascites, pleural effusion)?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Mucosal bleeding?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Lethargy or restlessness?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Liver enlargement &gt;2 cm?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Severe plasma leakage leading to shock (Dengue Shock Syndrome) or fluid accumulation with respiratory distress?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Severe bleeding as evaluated by a clinician?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Liver enzymes: AST or ALT &gt;1000?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Impaired consciousness?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
C. Exposure – Risk Factors

- Laboratory acquired?  
  - Yes  
  - No  
  - Unknown

- Blood donor?  
  - Yes  
  - No  
  - Unknown

- Blood product recipient?  
  - Yes  
  - No  
  - Unknown

- Organ donor?  
  - Yes  
  - No  
  - Unknown

- Organ transplant recipient?  
  - Yes  
  - No  
  - Unknown

- Breast fed infant?  
  - Yes  
  - No  
  - Unknown

- Infected in utero?  
  - Yes  
  - No  
  - Unknown

D. Exposure – Travel History

Did you travel outside of your Kansas County in the 15 days before the illness began?  
- Yes  
- No  
- Unknown

- City, County in Kansas you traveled to: ________________________________
- Date departed: _______________  Date returned: ________________________

Did you travel within the United States in the 15 days before the illness began?  
- Yes  
- No  
- Unknown

- City, State you traveled to: ________________________________
- Date departed: _______________  Date returned: ________________________

Did you travel internationally in the 15 days before the illness began?  
- Yes  
- No  
- Unknown

- City, Country you traveled to: ________________________________
- Date departed: _______________  Date returned: ________________________

What was the reason for travel?

- Tourism  
- Medical Tourism

- Business  
- Ecotourism

- Missionary/Volunteer/Researcher/Aid Work  
- Immigration to U.S.A.

- Peace Corps  
- Visiting Friends and Relatives

- Student  
- Unknown
Did the patient receive a pre-travel health consultation?

☐ Yes  ☐ No  ☐ Unknown

E. Exposure – Transmission

Please specify transmission methods.

What is the transmission origin?

☐ Foreign travel-related

☐ Domestic local transmission

☐ Domestic travel-related

☐ Unknown

What is the transmission mode?

☐ Mosquito-borne

☐ Blood-borne

☐ Unknown