# Shigellosis Report Form

## INTERVIEW

<table>
<thead>
<tr>
<th>EpiTrax #</th>
<th>Interviewer Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Call Attempts:</td>
<td>Date of Interview:</td>
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</tbody>
</table>

**Follow-up Status:**
- ☐ Interviewed
- ☐ Refused interview
- ☐ Lost to follow-up*

*At least 3 telephone attempts at different times of the day should be made before a case can be considered lost to follow-up.

**Respondent was:**
- ☐ Self
- ☐ Parent
- ☐ Spouse
- ☐ Other: ________________

## DEMOGRAPHICS

**Date of Birth:** ________________

**Age:** ________________

**Birth Gender:**
- ☐ Male
- ☐ Female

**Ethnicity:**
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

**Race:**
- ☐ White
- ☐ Black/African-American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other: ________________
- ☐ Unknown

## EPIDEMIOLOGICAL INFORMATION

**Check all that apply. Patient is a:**
- ☐ Food handler
- ☐ Healthcare worker
- ☐ Group living resident
- ☐ Day care attendee
- ☐ Day care worker
- ☐ School attendee
- ☐ School employee
- ☐ Laboratory employee
- ☐ Student in a laboratory class

**Occupation:** ________________

**Check all that apply:**
- ☐ Volunteer
- ☐ Retired
- ☐ Unemployed

**Did patient work or attend school or daycare while ill?**
- ☐ Yes
- ☐ No

*If yes, Dates worked/attended: ________________

**Under state regulation*, is patient to be excluded from work or daycare?**
- ☐ Yes
- ☐ No

*See K.A.R. 28-1-6 or Kansas Disease Investigation Guidelines for disease-specific information on exclusion criteria

*If yes, Date exclusion lifted: ________________

---

**Facility Name:** ________________

**Facility Address:** ________________

**Facility Phone Number:** ________________
CLINICAL INFORMATION

On what date did symptoms of illness begin?  
Onset Date: __________________________
Onset Time: __________________________
Diagnosis Date: __________________________

Clinical Symptoms (select all that apply):

☐ Diarrhea  ☐ Muscle/joint pain
If yes, Start date: ________________
Max # of stools in 24 hours: __________
☐ Abdominal pain/cramps  ☐ Fatigue/excessive tiredness
☐ Bloody stool  ☐ Headaches
☐ Nausea  ☐ Chills
☐ Vomiting  ☐ Fever
If yes, Start date: ________________
If yes, Highest temp: ______

☐ Any other symptoms: ________________

Was antimicrobial medication taken for this illness?  
☐ Yes (provide data below)  ☐ No

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Date Started</th>
<th>Date Ended</th>
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<tbody>
<tr>
<td>1.</td>
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Were you hospitalized?  
☐ Yes  ☐ No
Hospital Name(s): __________________________
Medical Record Number(s): __________________________
Admission Date: __________________________  Discharge Date: __________________________

Have symptoms of illness completely stopped?  
☐ Yes  ☐ No*
Recovery Date: __________________________
Recovery Time: __________________________

Are you pregnant?  
☐ Yes  ☐ No  If yes, Expected due date: __________

Do you have an underlying immunodeficiency?  
☐ Yes  ☐ No
If yes, Specify: __________________________

☐ Mortality Event (check here if patient died)

*If patient is still ill and antibiotic treatment has been completed, suggest patient discuss antibiotic susceptibility testing and further treatment with his or her healthcare provider.
CLINICAL INFORMATION: PAST MEDICAL HISTORY & RECENT MEDICATIONS

*These questions are about the patient’s past medical history and recent medications.*

**Have you been told by a physician that you have any of the following conditions?**  *Select all that apply.*

- [ ] Kidney disease
- [ ] Stomach ulcer disease
- [ ] Organ or bone marrow transplant
- [ ] Stomach surgery
- [ ] Chronic diarrhea
- [ ] Liver disease, including Hepatitis C
- [ ] Lupus
- [ ] Diabetes
- [ ] Leukemia or cancer (not skin cancer)
- [ ] Rheumatoid Arthritis
- [ ] HIV/AIDS
- [ ] Sickle Cell disease (not sickle cell trait)

**In the *month before* onset of illness, were any of the following medications taken?**  *Select all that apply.*

- [ ] Any type of insulin
- [ ] Any oral or intravenous (IV) steroid, such as prednisone
- [ ] Any form of radiation therapy
- [ ] Any immune-suppressing medication, such as cyclosporine, FK 506 (tacrolimus), or methotrexate, or other chemotherapy

**In the *month before* onset of illness, were any antibiotics taken?**  *This includes infrequent or prophylactic doses of antibiotics to prevent infection.*  

*IF YES, ANSWER THE QUESTIONS BELOW FOR EACH ANTIBIOTIC TAKEN. If the patient still has the container for the medication, ask them to retrieve it to help answer these questions.*

<table>
<thead>
<tr>
<th>1. Antibiotic Name: __________________________</th>
<th>Started (☐ during/☐ before) this illness</th>
</tr>
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<tbody>
<tr>
<td>For what illness or reason was this antibiotic taken?</td>
<td>________________________________</td>
</tr>
<tr>
<td>Was this antibiotic prescribed by a doctor?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Date antibiotic started: ________________</td>
<td>Date stopped: ________________</td>
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<tr>
<td># Days antibiotic was taken: ________________</td>
<td>Were any doses skipped/missed?</td>
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<td>For what illness or reason was this antibiotic taken?</td>
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<td>Was this antibiotic prescribed by a doctor?</td>
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INVESTIGATION: GENERAL EXPOSURE – TRAVEL HISTORY

In the 7 days prior to onset of illness, did you travel outside of the United States?

☐ Yes  ☐ No

*If yes, City, Country traveled to: ________________________________
Resort/Hotel Name(s): _________________________________________
Date left Kansas: ________________  Date left United States: __________
Date returned to KS: ________________  Date returned to US: __________

In the 7 days prior to onset of illness, did you travel outside of Kansas, but inside the United States?

☐ Yes  ☐ No

*If yes, City, State traveled to: ________________________________
Resort/Hotel Name(s): _________________________________________
Date left Kansas: __________________________
Date returned to KS: _______________________

In the 7 days prior to onset of illness, did you travel outside of your Kansas county of residence?

☐ Yes  ☐ No

*If yes, City, County traveled to: ________________________________
Resort/Hotel Name(s): _________________________________________
Date left county of residence: __________________________
Date returned to county of residence: _______________________

In the 7 days prior to onset of illness, did you attend any large gatherings or group events? This might include parties, conferences, camps, sporting events, family reunions, weddings, or funerals.

☐ Yes  ☐ No

*If yes, Event date: ________________________________
Event details (including location): _______________________________________

In the 7 days prior to onset of illness, did you eat any food that was brought by yourself or someone else from another country (for example, souvenir food)?

☐ Yes  ☐ No

*If yes, Describe food, including country of origin: ________________________________
_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________
**INVESTIGATION: CONTACTS**

In the 7 days prior to onset of illness, did you have contact with anybody with similar symptoms?

☐ Yes (add contact data below)  ☐ No  ☐ Unknown

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Relationship:</th>
<th>Age:</th>
<th>Onset Date:</th>
<th>EpiTrax Case Number:</th>
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In the 7 days prior to onset of illness, did you have contact with a friend or relative who lived or traveled outside of the United States in the month before contact?

☐ Yes  ☐ No  ☐ Unknown

*If yes, list countries: ________________________________

While you were experiencing symptoms, did you have any contact with others that could have resulted in *Shigella* transmission?

☐ Yes (add contact data below)  ☐ No  ☐ Unknown

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Relationship:</th>
<th>Age:</th>
<th>Disposition:</th>
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*If there are additional symptomatic persons identified, whether contact was before or after this patient’s onset of illness, fully investigate those persons as cases of shigellosis and complete a full case investigation form for each ill person. List EpiTrax #s of all symptomatic contacts here:*

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
INVESTIGATION: WATER EXPOSURES

In the 7 days prior to onset of illness, did you swim or wade in any recreational water (select all that apply, and provide name and location of pool/facility)?

☐ Public/city pool: ____________________________________________
☐ Water park: _________________________________________________
☐ Splash pad/splash park/interactive water feature: ________________
☐ Hotel/motel pool or spa: _____________________________________
☐ Kiddie/inflatable pool: _______________________________________  
☐ Sprinklers: _________________________________________________
☐ Irrigation/canal water: _______________________________________  
☐ Any natural water (lake, stream, reservoir, etc.): ________________
☐ Any other recreational water: _________________________________

In the 7 days prior to onset of illness, did you drink or may you have accidentally ingested any untreated/unfiltered water?

☐ Yes  ☐ No  ☐ Unknown

If yes, list source(s), location(s), and date(s) of exposure: __________________________

Provide the patient with educational and prevention materials as appropriate, and complete the administrative section below. If the patient is under 16 years of age, thank the responder for his or her time; this ends the interview. If the patient is 16 years of age or older, continue to the final section.

ADMINISTRATIVE

Public health interventions (select all that apply):  
☐ Hygiene education provided
☐ Follow-up of other household members
☐ Daycare inspection
☐ Work or daycare restriction for case
☐ Other: ________________________________

LHD Case Status (select one):  
☐ Confirmed
☐ Probable
☐ Suspect
☐ Not a case

Outbreak associated:

☐ Yes  ☐ No  ☐ Unknown

Outbreak Name: ________________________________

Date first reported to LHD: ________________

Date LHD investigation started: ________________

Date LHD investigation completed: ________________
INVESTIGATION: SEXUAL EXPOSURE QUESTIONS

THESE QUESTIONS ARE ONLY FOR THOSE PATIENTS WHO ARE 16 YEARS OF AGE OR OLDER.

Read to patient: Now I am going to ask you some questions about having sex. I need to ask you these questions even if some may not seem to apply to you. The questions may be sensitive, but your answers will be kept private, and they will help us understand how to do a better job of preventing Shigella infections.

**In the past 12 months, have you had sexual contact with a man?**
- ☐ Yes  ☐ No

*If yes:* How many male partners did you have in the **3 months** before becoming ill? __________
*If >0:* During the **7 days** before symptoms began, did you:
  - □ Have any anonymous sexual contact with a man?  ☐ Yes  ☐ No
  - □ Touch your partner’s anus with your mouth, without using a barrier?  ☐ Yes  ☐ No
  - □ Touch your partner’s anus with your hand, without using a barrier?  ☐ Yes  ☐ No
  - □ Have any anal-genital contact without a condom?  ☐ Yes  ☐ No

**In the past 12 months, have you had sexual contact with a woman?**
- ☐ Yes  ☐ No

*If yes:* How many female partners did you have in the **3 months** before becoming ill? __________
*If >0:* During the **7 days** before symptoms began, did you:
  - □ Have any anonymous sexual contact with a woman?  ☐ Yes  ☐ No
  - □ Touch your partner’s anus with your mouth, without using a barrier?  ☐ Yes  ☐ No
  - □ Touch your partner’s anus with your hand, without using a barrier?  ☐ Yes  ☐ No
  - □ Have any anal-genital contact without a condom?  ☐ Yes  ☐ No

**In the 7 days before symptoms began, did you visit any bathhouses?**
- ☐ Yes  ☐ No

*This completes the interview. Thank you for your time.*