Cancel Form

Toxic Shock Syndrome Supplemental Form

Kansas Department of Health

Epidemiologic Case History

* indicates required fields

Case Type*
○ *Human Case* ○ *Non Human Case*

Classification*
○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Deleted* ○ *Unknown*

Supplemental Form Status
○ *Not Done* ○ *Form Complete* ○ *Form in Progress* ○ *Form Approved* ○ *Form Sent to CDC*

Report Date*
mm/dd/yyyy

Patient Demographic Information

* indicates required fields

Last Name*	First Name*	Middle Name	Name Type*	Age

Age Unit
○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Date of Birth
mm/dd/yyyy

Race*
(Check all that apply)
☐ *American Indian or Alaska Native* ☐ *Asian* ☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander* ☐ *White* ☐ *Unknown*

Ethnicity*
○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown*

Sex*
○ *Failure to Report* ○ *Female* ○ *Male* ○ *Other* ○ *Transexual* ○ *Unknown*

Street Address

City	County	State	Zip

Evening Phone
###-###-####

Daytime Phone
###-###-####

Occupation

Person Providing Report

Name of Reporting Facility*

Clinical Findings Major Criteria

Fever (Fahrenheit)
(highest-if not recorded, leave blank)

Hypotension (lowest)

Systolic	Diastolic	Syncope?	Orthostatic dizziness?
		○ *Yes* ○ *No*	○ *Yes* ○ *No* ○ *Unknown*

Rash?
○ *Yes* ○ *No* ○ *Unknown*

If Yes,
○ *Generalized* ○ *Focal*

Describe

Desquamation?
○ *Yes* ○ *No* ○ *Unknown*

If Yes, describe

Signs and Symptoms (First 4 Days of Illness)

Vomiting? ○ *Yes* ○ *No* ○ *Unknown*	**Diarrhea?** ○ *Yes* ○ *No* ○ *Unknown*	**Abdominal Pain?** ○ *Yes* ○ *No* ○ *Unknown*	**Myalgia?** ○ *Yes* ○ *No* ○ *Unknown*
Sore Throat? ○ *Yes* ○ *No* ○ *Unknown*	**Conjunctival Hyperemia?** ○ *Yes* ○ *No* ○ *Unknown*	**Oropharyngeal Hyperemia?** ○ *Yes* ○ *No* ○ *Unknown*	**Injected Tongue?** ○ *Yes* ○ *No* ○ *Unknown*
Vaginal Hypermia? ○ *Yes* ○ *No* ○ *Unknown*	**Vaginal Discharge?** ○ *Yes* ○ *No* ○ *Unknown*	**Vaginal Ulceration?** ○ *Yes* ○ *No* ○ *Unknown*	**Disorientation?** ○ *Yes* ○ *No* ○ *Unknown*

Seizures? ○ *Yes* ○ *No* ○ *Unknown*	**Cardiac Arrhythmia?** ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, describe**

Laboratory Data (Most Abnormal Values in First 4 Days of Illness)

Chest X-Ray ○ *Positive* ○ *Negative* ○ *Not Done* ○ *Unknown*	**If Abnormal, describe:**

Cultures

Was patient taking antibiotics when culture(s) performed? ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, which sites?**

Tampon/Napkin/Minipad Use

If applicable (during period when patient became ill)

Products Used

○ *Tampons only* ○ *Napkins only* ○ *Minipads only* ○ *Tampons and Napkins*
○ *Tampons and Minipads* ○ *Napkins and Minipads* ○ *Tampons, Napkins, and Minipads* ○ *Sea Sponge*
○ *Unknown* ○ *Other (specify)*_____

Most frequently used, judged by time (If only one brand was used before onset of symptoms, list only that brand)

Brand Name

○ *Assure* ○ *Kotex-Plastic Inserter* ○ *Kotex-Stick Inserter* ○ *Kotex-Inserter Unknown* ○ *o.b.*
○ *Playtex-Deodorized* ○ *Playtex-Non-deodorized* ○ *Playtex-Deodorant Unknown* ○ *Pursettes* ○ *Rely*
○ *Tampax* ○ *Other (specify):*_____ ○ *Unknown*

Style (absorbency)

○ *Super-plus* ○ *Super* ○ *Regular* ○ *Junior* ○ *Unknown*

Tampon Brand No. 2

Brand Name

○ *Assure* ○ *Kotex-Plastic Inserter* ○ *Kotex-Stick Inserter* ○ *Kotex-Inserter Unknown* ○ *o.b.*
○ *Playtex-Deodorized* ○ *Playtex-Non-deodorized* ○ *Playtex-Deodorant Unknown* ○ *Pursettes* ○ *Rely*
○ *Tampax* ○ *Other (specify):*_____ ○ *Unknown*

Style (absorbency)

○ *Super-plus* ○ *Super* ○ *Regular* ○ *Junior* ○ *Unknown*

Was Brand No. 1 the only tampon brand used during period when patient became ill? ○ *Yes* ○ *No* ○ *Unknown*	**Napkin brand**	**Minipad brand**

How was information in this section verified?

○ *Patient's Memory* ○ *Patient viewing product box* ○ *Interviewer viewing product box* ○ *Other (describe)*_____

Recurrence Information For Menstruation-Associated Cases

Has patient had similar illness in past during menstrual period?	**If Yes, how many episodes?**
○ *Yes* ○ *No* ○ *Unknown*	○ *One* ○ *Two* ○ *Three* ○ *More Than Three*

Other Information

Please describe any other pertinent or unusual features of this case

How was case reported to Health Department

○ *By patient or relative* ○ *By physician* ○ *By hospital* ○ *Other* _____

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