

DEPARTMENT OF HEALTH & HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL  
P.O. BOX 2087  
FT. COLLINS, CO 80522-2087

### PLAGUE CASE INVESTIGATION REPORT

Date of Report	Mo. <input type="text"/>	Day <input type="text"/>	Year <input type="text"/>
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#### PATIENT IDENTIFICATION

Name (last, first, M.I.)	Telephone No. (Area Code)
Address	City State County

AGE <input type="text"/>	SEX 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	RACE 1 <input type="checkbox"/> White (not Hispanic) 2 <input type="checkbox"/> Black (not Hispanic)	3 <input type="checkbox"/> Hispanic 4 <input type="checkbox"/> Asian or Pacific Islander	5 <input type="checkbox"/> Amer. Indian or Alaskan 6 <input type="checkbox"/> Unspecified	Date Hospitalized Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>
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Person making call	Person taking call
Agency	Agency
Telephone (Area Code)	Telephone (Area Code)

Has local health department been notified?  Yes  No If Yes, give name and address of person contacted.

Physician(s) \_\_\_\_\_ Telephone(s) (Area Code) \_\_\_\_\_

City \_\_\_\_\_ Hospital \_\_\_\_\_ Telephone (Area Code) \_\_\_\_\_

#### ILLNESS

Date of Onset of Illness Symptoms:

Mo.	Day	Yr.
<input type="text"/>	<input type="text"/>	<input type="text"/>

Signs

Temperature \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ Date

Bubo Inguinal  Femoral  Other  Size (cm) Describe \_\_\_\_\_  
 Cervical  Axillary  --R  --L  Tender  Yes  No Erythema  Yes  No

Skin Ulcer  Yes  No Location \_\_\_\_\_ Insect Bite(s)  Yes  No Location \_\_\_\_\_

Cough?  Yes  No Date of Onset of Cough    Cough productive?  Yes  No

Current condition and prognosis: \_\_\_\_\_

Outcome: Survived  Discharge date

Died  Autopsy:  Yes  No (If yes, please attach autopsy report.)

#### PRIVACY ACT STATEMENT

The Centers for Disease Control, an Agency of the Department of Health and Human Services, is authorized to solicit this information under provisions of the Public Health Service Act, Section 301, (42 U.S.C. 241). Response in this case is voluntary, and there is no penalty for non response. The information requested is considered relevant and necessary to the investigation of health problems associated with plague. The individually-identified data requested may be shared with health departments and other public health or cooperating medical authorities. An accounting of such disclosures will be made available to the subject individual upon request.

LABORATORY

Chest X-ray  Yes  No  Unknown      Pneumonia  Yes  No  Unknown      Date  Mo.  Day  Yr.

WBC Count \_\_\_\_\_ Left Shift ---  Yes --  No      Bands \_\_\_\_\_      Polys \_\_\_\_\_      Lymph \_\_\_\_\_

Mono \_\_\_\_\_      Eos \_\_\_\_\_      Bas \_\_\_\_\_

Bacteria on blood smear?  Yes  No  Don't know \_\_\_\_\_

Blood cultures taken?  Yes  No      How many? \_\_\_\_\_      Results? \_\_\_\_\_

Bubo Aspirate: <input type="checkbox"/> Yes <input type="checkbox"/> No		POS.	NEG.	Sputum: <input type="checkbox"/> Yes <input type="checkbox"/> No		POS.	NE		
Date	Mo. Day Yr.	Gram Stain	<input type="checkbox"/>	<input type="checkbox"/>	Date	Mo. Day Yr.	Gram Stain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Wayson Stain (or Wright's, Giemsa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Wayson Stain (or Wright's, Giemsa)	<input type="checkbox"/>	<input type="checkbox"/>
		FA (Plague)	<input type="checkbox"/>	<input type="checkbox"/>			FA (Plague)	<input type="checkbox"/>	<input type="checkbox"/>
		Culture	<input type="checkbox"/>	<input type="checkbox"/>			Culture	<input type="checkbox"/>	<input type="checkbox"/>

Serologies:

S<sub>1</sub> result \_\_\_\_\_      Date(s) Serum Drawn  Mo.  Day  Yr.

S<sub>2</sub> result \_\_\_\_\_       Mo.  Day  Yr.

ANTIBIOTICS

Treatment	Date Started Mo. Day	Date Stopped Mo. Day	Dosage & Schedule
1 _____	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	1. _____
2 _____	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	2. _____
3 _____	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	3. _____

Isolation:  Respiratory       Wound precautions only       None

EPIDEMIOLOGY

Whereabouts during 10 days before onset on (dates) (Include all outdoor activities):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other persons ill after same exposure? Names and whereabouts:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did patient handle sick or dead rodents, rabbits, or other animals?  Yes  No      If so, where? \_\_\_\_\_

Patient recall flea or other insect bites?  Yes  No      Contact with human plague patient?  Yes  No

Wild animal contact, including hunting?  Yes  No      Contacts or relatives who died in past week?  Yes  No

ts (kind and number) \_\_\_\_\_

Illness in pets?  Yes  No      Describe: \_\_\_\_\_

Pets free roaming?  Yes  No  Don't know

EPIDEMIOLOGY (Cont'd.)

Community Contacts During Illness: Name*	Location and Time (Setting and Circumstances)	Date
a) Family and household:		
b) Work or school:		
c) Friends/acquaintances:		
d) Hospital:		

\*When a group too large to list is involved, the location, setting, time and date will allow relevant persons to be traced (e.g., church, school, social activities, etc.)

To carry out field investigation in the home or work area, it would be helpful to get permission to enter and work on private property.

Who should be contacted for such permission? Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
(Area Code)