

First three letters of patient's last name:

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HOUSEHOLD CONTACTS - DETAILS

Name 5	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 6	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 7	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 8	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 9	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 10	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 11	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 12	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 13	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 14	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 15	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 16	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment
Name 17	Relationship	Age	Gender	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Telephone Number	Similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)	Comment