

**COCCIDIOIDOMYCOSIS (VALLEY FEVER)  
CASE HISTORY REPORT**



CENSUS TRACT: \_\_\_\_\_ VCMR ID: \_\_\_\_\_

Patient name-last	first	middle initial	Date of Birth	Age	Sex
Address- number, street		City	State	ZIP Code	
Telephone number		Work ( )		Cell ( )	
Home ( )					
Race (check one)				Ethnicity (check one)	
<input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____				<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
If Asian/Pacific Islander, please check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____					
Occupation			City		
Was the patient incarcerated 1 month prior to onset of disease? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify where and when. _____					

**PRESENT ILLNESS**

Onset date	Diagnosis date	Attending or consulting physician	Fax number ( )	Telephone number ( )
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date	Discharge date	Facility/Hospital Name	
If female: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Medical record number	Outcome <input type="checkbox"/> Recovered <input type="checkbox"/> Fatal   Date of Death: _____	
Check any symptoms that apply: <input type="checkbox"/> Influenza-like illness (e.g. fever, chest pain, cough, muscle pain, headache, etc.) <input type="checkbox"/> Pneumonia/pulmonary lesion <input type="checkbox"/> Rash: Erythema nodosum/Erythema multiforme <input type="checkbox"/> Bone, joint, or skin involvement <input type="checkbox"/> Meningitis <input type="checkbox"/> Disseminated disease <input type="checkbox"/> Other: Specify _____		Check all significant past medical history that apply: <input type="checkbox"/> Diabetes                      If checked, What type?: <input type="checkbox"/> Type I   OR <input type="checkbox"/> Type II <input type="checkbox"/> Asthma <input type="checkbox"/> Other chronic lung disease   If checked, Specify _____ <input type="checkbox"/> Chronic dialysis <input type="checkbox"/> Organ transplant <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Injection drug use <input type="checkbox"/> Other                              If checked, Specify _____		
Was the patient previously diagnosed with coccidioidomycosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   If yes, when and where? _____				

**DIAGNOSTIC TESTS (List all tests performed and attach laboratory results.)**

Type of Test	Source of Specimen	Date Collected	Results	Name and Address of Laboratory
Serological				
Culture				
Tissue specimen (Biopsy or autopsy?)				
Skin Test				
Other (Specify)				

**REMARKS**

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**CONTACT INFORMATION**

Investigator's name (print)	Investigator's signature	Date	Telephone number ( )
Agency name/Health District	Supervisor's signature (if applicable)	Medical Director's signature (if applicable)	