

CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Form approved OMB No. 0920-0728

Demographic data:

Case ID: \_\_\_\_\_

Classify case based on CDC case definition: Confirmed Probable Sex: Male Female

State of residence: \_\_\_\_\_ County: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth (mm/yyyy): \_\_\_\_\_

Ethnic origin: Race (check all that apply): Hispanic or Latino White American Indian or Alaska Native Not Hispanic or Latino Black or African American Native Hawaiian or other Pacific Islander Unknown Asian Unknown

Physician's name: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ Email: \_\_\_\_\_

Clinical data: (For dates, be as specific as possible. However, approximations [e.g., mm/yyyy] are okay.)

Date of onset of illness / symptoms: \_\_\_\_\_ ( Unknown date; unable to approximate)

Signs and symptoms: Diarrhea: Yes No Unknown If yes, maximum number stools per day: \_\_\_\_\_ (unknown = 999) Weight loss: Yes No Unknown If yes, baseline weight: \_\_\_\_\_ lbs. (unknown = 999) Number of pounds lost: \_\_\_\_\_ Fever (or felt feverish): Yes No Unknown If yes, temperature: \_\_\_\_\_ degrees F (unknown or not measured = 999) Other symptoms (specify): \_\_\_\_\_ Fatigue: Yes No Unknown Anorexia: Yes No Unknown Nausea: Yes No Unknown Vomiting: Yes No Unknown Abdominal cramps: Yes No Unknown

Hospitalized (at least overnight): Yes No Unknown If yes, name of hospital: \_\_\_\_\_ Date of admission: \_\_\_\_\_

Date stool collected for Cyclospora testing: \_\_\_\_\_ (If multiple stools, specify below or on p. 2.) Test results: Positive Negative Unknown (or pending) If known, specify testing methods and laboratories, including, if applicable, testing done by state or CDC labs: Results from state lab (not applicable: ): Positive Negative Unknown (or pending) Results from CDC lab (not applicable: ): Positive Negative Unknown (or pending)

Has the case-patient been treated (or is he/she being treated) for cyclosporiasis? Yes No Unknown If yes, what medication(s)? Trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim) Other (specify): \_\_\_\_\_ Unknown

Is case-patient allergic to (or intolerant of) sulfa drugs? Yes No Unknown

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, GA 30333; ATTN: PRA (0920-0728).

**Exposures during 2 weeks before onset of illness:**

(For dates, be as specific as possible. However, approximations [e.g., mm/yyyy] are okay.)

History of travel (during 2 weeks before onset of illness):	Yes	No	Unknown
<b>International travel (country):</b> ( <b>Unknown dates of travel and unable to approximate</b> )			
(1) _____	Departure date: _____	Return date: _____	
(2) _____	Departure date: _____	Return date: _____	
(3) _____	Departure date: _____	Return date: _____	
<b>U.S. travel (state):</b> ( <b>Unknown dates of travel and unable to approximate</b> )			
(1) _____	Departure date: _____	Return date: _____	
(2) _____	Departure date: _____	Return date: _____	
(3) _____	Departure date: _____	Return date: _____	

**Fresh produce exposures (produce eaten or tasted during 2 weeks before onset of illness):**

**Fresh berries:** Yes (If yes, specify types; check all that apply) No Unknown

Strawberries Blackberries Blueberries  
Raspberries Black raspberries Golden raspberries Unknown type of berry  
Other types of berries (specify): \_\_\_\_\_

**Fresh herbs:** Yes (If yes, specify types; check all that apply) No Unknown

Cilantro Oregano Thyme Mint Dill Parsley Rosemary  
Basil (specify types): Sweet basil Thai basil (i.e., green leaves and purple stems)  
Purple basil (i.e., purple leaves and stems)  
Other types of herbs (specify): \_\_\_\_\_  
Unknown type of herb

**Lettuce:** Yes (If yes, specify types; check all that apply) No Unknown

Mesclun (a.k.a., spring mix, field greens, baby greens, & gourmet salad mix)  
Arugula  
Other types of lettuce (specify): \_\_\_\_\_  
Unknown type of lettuce

**Other types of fresh produce:** Yes (If yes, specify types; check all that apply) No Unknown

Fruit, other than berries (specify types): \_\_\_\_\_  
Snow peas (flat, shiny pea pods containing tiny peas)  
Other types of fresh produce (specify): \_\_\_\_\_  
Unknown type of fresh produce

**Did the case-patient attend any events** (e.g., wedding reception) (during **2 weeks** before onset of illness)?

Yes No Unknown

If yes, specify type of social or other event: \_\_\_\_\_ Event date: \_\_\_\_\_

**Does the case-patient know of other ill persons?** Yes No Unknown

If yes, did health department obtain contact information and investigate further (provide comments below)?

Yes No Under consideration (or pending) Unknown

**Comments and additional data:**

**Name** (person filling out form): \_\_\_\_\_ **Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Name of investigating health department:** \_\_\_\_\_ **Date form submitted:** \_\_\_\_\_