***Form 1: Monkeypox Case Investigation Form*** **Please Print** **Form Approved OMB NO. 0920-0008**
(Circled questions are high priority)

(1.) State:_____ (2.) State or Local ID#:_____ (3.) CDC MPox Unique ID #:_____ (4.) Date reported to CDC:_____

## CASE CONTACT INFORMATION

(5.) CASE NAME:_____/_____/_____/_____/_____
Last First Middle Suffix Nickname/Alias

6. ADDRESS: _____
Street Address, Apt. #. (City) County (State) Zip Code

## CASE INFORMATION

(7.) DATE OF BIRTH: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

8. AGE: ____ 9. AGE UNIT: ☐ Years ☐ Months ☐ Days

(10.) GENDER: ☐ Male ☐ Female

11. ETHNICITY: ☐ Hispanic ☐ Non-Hispanic

12. RACE: (Check all that apply)
☐ Am. Indian/Alaska Native
☐ Black/African American ☐ White
☐ Hawaiian/Pacific Islander ☐ Unknown

(13.) OCCUPATION: _____
13a. ☐ OCCUPATION N/A (e.g. child or not working)

(14.) SOURCE OF EXPOSURE:

☐ Animal, Prairie Dog ☐ Animal, Gambian Rat

☐ Animal, Rabbit ☐ Animal, Wallaby

☐ Animal, Rope Squirrel ☐ Animal, African Tree Squirrel

☐ Animal, Other: Specify_____

☐ Symptomatic Person: Specify Relationship _____

☐ Unknown ☐ Other Exposure Source: Specify_____

(15.) DATE OF FIRST EXPOSURE: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

(16.) DATE OF LAST EXPOSURE: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

(17.) IF ANIMAL, STATUS OF THE ANIMAL AT TIME OF EXPOSURE:
☐ Alive and well ☐ Alive and ill ☐ Dead ☐ Unknown

17a. IF ILL ANIMAL: DATE OF ANIMAL ILLNESS ONSET

___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

17b. IS LIVE ANIMAL OR CARCASS AVAILABLE FOR TESTING:
☐ Yes ☐ No ☐ Unknown

(18.) IF ANIMAL, WHERE WAS IT PURCHASED:

_____/_____/_____
Specific Location City State

(19.) IF ANIMAL, TYPE OF EXPOSURE TO ANIMAL: (Check all that apply)
☐ Bite ☐ Petting/Handling ☐ Other, Specify: _____

(20.) IF HUMAN, TYPE OF EXPOSURE: (Check all that apply)
☐ Skin-to-skin contact ☐ ≤ distance of 6 feet for >3 hours
☐ Contact with respiratory secretions
☐ Other, Specify: _____

(21.) EXPOSURE SETTING: (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Athletics | ☐ School | ☐ Correctional facility | ☐ Pet Store |
| ☐ College | ☐ Home | ☐ Place of worship | ☐ Zoo |
| ☐ Community | ☐ Hospital | ☐ Work | ☐ Animal Shelter |
| ☐ Daycare | ☐ Int'l travel | ☐ Swap Meet | ☐ Other |
| ☐ Dr's. Office | ☐ Military | ☐ Veterinary Clinic | ☐ Unknown |

(21a.) IF OTHER, SPECIFY: _____

(21b.) WHERE DID EXPOSURE OCCUR:

_____/_____/_____
Specific Location City State

## REPORTING SOURCE AND INFORMATION

(22.) DATE OF REPORT TO STATE OR LOCAL PUBLIC HEALTH:

___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

23. REPORTED BY: _____
Name/Institution

24. REPORTER PHONE NUMBER: (_____)_____

25. REPORTER ADDRESS:_____

(26.) STATE HEALTH DEPT. NOTIFIED: ☐ Yes ☐ No ☐ Unknown

27. FORM COMPLETED BY:

_____/_____/____
Last First Middle

28. AFFILIATION: _____

(29.) DATE FORM COMPLETED: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

## TRANSFUSION AND DONATION HISTORY

(30.) DONATED BLOOD OR PLASMA 28 DAYS OR LESS BEFORE SYMPTOM ONSET:
☐ Yes ☐ No ☐ Unknown

(30a) IF YES, SPECIFIC LOCATION AND DATE: _____

_____

(31.) RECEIVED BLOOD OR BLOOD PRODUCT(S) 28 DAYS OR LESS BEFORE SYMPTOM ONSET:
☐ Yes ☐ No ☐ Unknown

(31a) IF YES, SPECIFIC LOCATION AND DATE: _____

_____

## CURRENT ILLNESS

32. HAS THE CASE HAD A FEVER AS PART OF THIS ILLNESS:
☐ Yes, measured with thermometer ☐ Yes, not measured with thermometer
☐ No ☐ Unknown

32a. IF YES, DATE OF FEVER ONSET: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

32b. HAS THE CASE HAD A MEASURED TEMPERATURE ≥ 99.3°F(37.4°C) :
☐ Yes ☐ No ☐ Unknown

32c. IF YES, HIGHEST TEMPERATURE: _____F or _____C

33. HAS THE CASE HAD A RASH:
☐ Yes ☐ No ☐ Unknown

33a. IF YES, DATE OF RASH ONSET: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

33b. IF YES, TYPE OF RASH: (check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Macular | ☐ Yes | ☐ No | ☐ Unk. | Vesicular | ☐ Yes | ☐ No | ☐ Unk. |
| Papular | ☐ Yes | ☐ No | ☐ Unk. | Pustular | ☐ Yes | ☐ No | ☐ Unk. |
| Scabbing | ☐ Yes | ☐ No | ☐ Unk. | Drying | ☐ Yes | ☐ No | ☐ Unk. |
| Umbilicated | ☐ Yes | ☐ No | ☐ Unk. | Unknown | ☐ Yes | ☐ No | ☐ Unk. |
| Hemorrhagic | ☐ Yes | ☐ No | ☐ Unk. | Other | ☐ Yes | ☐ No | ☐ Unk. |

33c. IF OTHER,SPECIFY:_____

33d. IF RASH, NUMBER OF LESIONS AT DATE OF CASE REPORT:
☐ < 25 ☐ 25-99 ☐ 100-499 ☐ >= 500

33e. IF RASH, NUMBER OF LESIONS AT HEIGHT OF ILLNESS:
☐ < 25 ☐ 25-99 ☐ 100-499 ☐ >= 500

34. WHAT OTHER SIGNS OR SYMPTOMS WHERE PRESENT:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rhinorrhea | ☐ Yes | ☐ No | ☐ Unk. | Wheeze | ☐ Yes | ☐ No | ☐ Unk. |
| Cough | ☐ Yes | ☐ No | ☐ Unk. | Stridor | ☐ Yes | ☐ No | ☐ Unk. |
| Lymphadenopathy | ☐ Yes | ☐ No | ☐ Unk. | Abnormal CXR | ☐ Yes | ☐ No | ☐ Unk. |
| Sore Throat | ☐ Yes | ☐ No | ☐ Unk. | Headache | ☐ Yes | ☐ No | ☐ Unk. |
| Sweats | ☐ Yes | ☐ No | ☐ Unk. | Dyspnea | ☐ Yes | ☐ No | ☐ Unk. |
| Chills | ☐ Yes | ☐ No | ☐ Unk. | Diarrhea | ☐ Yes | ☐ No | ☐ Unk. |
| Nausea/Vomiting | ☐ Yes | ☐ No | ☐ Unk. | Myalgia | ☐ Yes | ☐ No | ☐ Unk. |
| Malaise | ☐ Yes | ☐ No | ☐ Unk. | Backache | ☐ Yes | ☐ No | ☐ Unk. |
| Abdominal pain | ☐ Yes | ☐ No | ☐ Unk. | Unknown | ☐ Yes | ☐ No | ☐ Unk. |

34a. ☐ OTHER: (e.g. Altered mental status)

34b. SPECIFY: _____

35. WHAT WAS THE FIRST SIGN OR SYMPTOM NOTED:

_____

35a. DATE OF FIRST SIGN OR SYMPTOM ONSET:

___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

## CLINICAL COURSE AND OUTCOME

36. DATE OF INITIAL EVALUATION: ___ ___/___ ___/ ___ ___ ___ _
Month Day Year

36a. PLACE OF EVALUATION:_____/_____/_____
Specific Location City State

36b. NAME OF CLINICIAN: _____

37. CASE ADMITTED TO HOSPITAL:
☐ Yes ☐ No ☐ Unknown

37a. IF YES, REASON FOR HOSPITALIZATION:
☐ Severity of illness
☐ Isolation/observation
☐ Social
☐ Complication
☐ Other, specify: _____

38. DID THE CASE DEVELOP ANY COMPLICATIONS:
☐ Yes ☐ No ☐ Unknown

38a. IF YES, CHECK ALL THAT APPLY:
☐ Skin, infected lesions/abscesses ☐ Pneumonia
☐ Corneal ulcer or keratitis ☐ Hemorrhage
☐ Encephalitis/meningitis ☐ Shock
☐ Bacterial sepsis
☐ Other, specify: _____

39. DID THE CASE DIE FROM MONKEYPOX ILLNESS OR ANY MONKEYPOX COMPLICATIONS: ☐ Yes ☐ No ☐ Unknown

39a. IF YES, DATE OF DEATH: ___ ___/___ ___/ ___ ___ ___ ___
Month Day Year

## LRN NON-VARIOLA ORTHOPOX TESTING

40. LABORATORY RESPONSE NETWORK PCR TEST FOR NON-VARIOLA ORTHOPOX: ☐ Yes ☐ No ☐ Unknown

40a. IF YES, LABORATORY RESULTS:
☐ Positive ☐ Negative ☐ Pending

40b. IF YES, DATE OF LAB RESULTS: _____/_____/ _____
Month Day Year

## STATE CASE CLASSIFICATION

41. WHAT IS THE STATE CASE CLASSIFICATION:

| | | | |
|---|---|---|---|
| Confirmed | ☐ | Person of Interest | ☐ |
| Probable | ☐ | Excluded | ☐ |
| Suspect | ☐ | | |

## VACCINATION AND MEDICAL HISTORY

42. SMALLPOX VACCINATION EVER:
☐ Yes ☐ No ☐ Unknown

42a. IF YES, NUMBER OF DOSES: ☐ One ☐ More than one

42b. IF YES, DATE OF LAST VACCINATION: ___ ___/___ ___/ ___ ___ ___
Month Day Year

43. IF DATE UNKNOWN, YEAR OF LAST DOSE: ___ ___ ___ ___

or AGE (YEARS)_____

43a. TEN OR MORE YEARS SINCE VACCINATION:
☐ Yes ☐ No ☐ Unknown

44. SMALLPOX VACCINATION SCAR PRESENT:
☐ Yes ☐ No ☐ Unknown

45. VACCINE "TAKE" RECORDED AT 7 DAYS (6-8 DAYS):
☐ Yes ☐ No ☐ Unknown

45a. IF YES, RESULT: ☐ Major ☐ Equivocal ☐ Unknown

46. IF EXPOSED AND NOT VACCINATED, GIVE REASON:
☐ Vaccinated within past 3 years
☐ Case refusal ☐ Case forgot
☐ Medical contraindication ☐ Unaware of need to be vaccinated
☐ Vaccination site unavailable/unknown
☐ Did not know they had been exposed
☐ Other, specify: _____

47. IF FEMALE, PREGNANT: ☐ Yes ☐ No ☐ Unknown

47a. IF YES NUMBER OF WEEKS: _____

48. PRE-EXISTING IMMUNOCOMPROMISING MEDICAL CONDITIONS (i.e., LEUKEMIA, OTHER CANCERS, HIV/AIDS): ☐ Yes ☐ No ☐Unknown

49. HISTORY OF VARICELLA: ☐ Yes ☐ No ☐ Unknown

49a. IF YES, YEAR OF VARICELLA ___ ___ ___ ___ or AGE (YEARS) _____

50. HISTORY OF VARICELLA VACCINATION: ☐ Yes ☐ No ☐ Unknown

50a. IF YES, DATE OF 1st DOSE: _____/_____/ _____
Month Day Year

50b. IF YES, DATE OF 2nd DOSE: _____/_____/ _____
Month Day Year

51. DURING THE PAST MONTH, ANY PRESCRIBED IMMUNOCOMPROMISING OR IMMUNOMODULATING MEDICATIONS INCLUDING STEROIDS:
☐ Yes ☐ No ☐ Unknown

**STATE OR LOCAL ID#_____** **CDC MPox UNIQUE ID#_____**