



# 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 Home ( )		Work ( )	Cell ( )		
RACE (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other: _____			ETHNICITY (check one) <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 (give exact job) and kind of business or industry at date of onset					

## 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)				

## EPIDEMIOLOGIC RISK FACTORS

Country of Birth:  US  Other: \_\_\_\_\_ If not born in the US, specify month and year of arrival. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

How long has the patient lived at their present residence? \_\_\_\_\_ If less than 4 weeks prior to illness, where did they reside? \_\_\_\_\_

## EXPOSURE TO DUST

During the 1 to 4 weeks prior to illness, did the patient .....

Consider their job to be (check one):  Outdoor  Indoor  Both

Participate in any of the following outdoor activities:  Yard work  Landscaping  Earth digging  Building  Outdoor house repair  Farming

Patient name (last, first) \_\_\_\_\_ Date of Birth \_\_\_\_\_

During the **1 to 4 weeks** prior to illness, has the patient .....

Participate in outdoor recreational activities?  Yes  No  Unknown If yes, what activity and location? \_\_\_\_\_

Been in an area in sight of earth excavation?  Yes  No  Unknown If yes, where (check one):  Residence  Work  Both Other \_\_\_\_\_

Been in an area in sight of construction?  Yes  No  Unknown If yes, where (check one):  Residence  Work  Both Other \_\_\_\_\_

Been in a dust storm?  Yes  No  Unknown If yes, where and when? \_\_\_\_\_

Regularly opened their windows:  House  Car

Worked, traveled, or resided in the following areas?

- Mojave Desert Area, CALIF.  Central California Valley (includes San Joaquin Valley)  
 Arizona  New Mexico  Southern Nevada  Southwestern Texas  Southern Utah  
 Northern Mexico  Central or South America  Other \_\_\_\_\_

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**REMARKS**

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Educated patient according to B-73.

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)	