Smallpox Case Investigation (Form 1A)

STATE Case Report # _____

Patient Information

1. DATE OF CASE INTERVIEW: Month Day Year

2. NAME OF PERSON FILING THIS CASE:
Last: _____ First: _____

3. PATIENT'S NAME:

Last: _____ First: _____ Middle Name: _____ Suffix: _____ Nickname: _____

4. DATE OF BIRTH: Month Day Year

5. AGE: _____

6. GENDER: ☐ Male ☐ Female

7. RACE: Mark all that apply:
☐ White
☐ Black/African American
☐ Asian/Pacific Islander
☐ Native American/Alaskan
☐ Other, Please Specify: _____

8. ETHNICITY: ☐ Hispanic ☐ Non-Hispanic

9. HOME ADDRESS:

_____
Street Address, Apt No. City State Zip Code

10. TELEPHONE: Home: Area Code Number Work: Area Code Number Other: Area Code Number

11. INTERVIEW LANGUAGE: _____

12. COUNTRY OF BIRTH: _____

13. INFORMATION PROVIDED BY: ☐ Case ☐ Household Member ☐ Other Family Member ☐ Other (Specify):_____

IF NOT CASE, NAME: Last: _____ First: _____ Middle Initial: _____

TELEPHONE: Home: Area Code Number Work: Area Code Number

14. ADMITTED TO HOSPITAL? ☐ Yes ☐ No ☐ Unknown IF YES, DATE OF ADMISSION: Month Day Year

HOSPITAL NAME:

_____
City State

MEDICAL RECORD #: _____

Vaccine and Medical History

15. SMALLPOX VACCINATION PRIOR TO OUTBREAK? ☐ Yes ☐ No ☐ Unknown
Note: Routine childhood smallpox vaccinations stopped in the United States in 1971; however, health care workers were vaccinated until the late 1970s and new military recruits not previously vaccinated were vaccinated until 1990.

DATE OF LAST VACCINATION: Month Day Year OR AGE AT VACCINATION: _____

16. IS A SMALLPOX VACCINATION SCAR PRESENT? ☐ Yes ☐ No ☐ Unknown
Note: This may be confused with BCG scars in immigrants.

17. SMALLPOX VACCINATION DURING THIS OUTBREAK? ☐ Yes ☐ No ☐ Unknown

DATE OF VACCINATION: Month Day Year

18. VACCINATION RECORD: ☐ Yes ☐ No ☐ Unknown

19. VACCINE "TAKE" RECORDED: ☐ Yes ☐ No ☐ Unknown

20. HISTORY OF VARICELLA DISEASE? ☐ Yes ☐ No ☐ Unknown

21. HISTORY OF VARICELLA VACCINATION? ☐ Yes ☐ No ☐ Unknown

VACCINE DATE, IF KNOWN:
Note: Varicella vaccine available in 1995. Month Day Year

22. PRE-EXISTING IMMUNOCOMPROMISING MEDICAL CONDITIONS, INCLUDING LEUKEMIA, OTHER CANCERS, HIV/AIDS? ☐ Yes ☐ No ☐ Unknown

IF YES, PLEASE SPECIFY: _____

23. FOR FEMALES OF 15-44 YEARS OF AGE, PREGNANT? ☐ Yes ☐ No ☐ Unknown

24. DURING THE PAST MONTH, ANY PRESCRIBED IMMUNOCOMPROMISING/IMMUNOMODULATING MEDICATIONS INCLUDING STEROIDS? ☐ Yes ☐ No ☐ Unknown

IF YES, PLEASE SPECIFY: _____ FOR WHAT MEDICAL CONDITION? _____

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