Smallpox Case Investigation Supplementary (Form 1B)

Patient Information

2. NAME OF PERSON FILING THIS CASE:
   Last: __________________________  First: __________________________  Middle Initial: ______

3. PATIENT’S NAME:
   Last: __________________________  First: __________________________  Middle Name: __________________________  Suffix: ______  Nickname: __________________________

4. ADMITTED TO 2ND HOSPITAL OR ISOLATION SITE?  
   Yes  No  Unknown  
   IF YES, DATE OF ADMISSION:   Month  Day  Year

   HOSPITAL NAME: __________________________  2ND HOSPITAL MEDICAL RECORD #: __________________________

   City  State

Clinical Course

5. SMALLPOX TYPES*: RASH (MOST SEVERE STAGE):
   ☐ Ordinary Type: ☐ Confluent – Face and other site  ☐ Semi-confluent – Face only  ☐ Discrete lesions
   ☐ Modified Type
   ☐ Flat Type
   ☐ Hemorrhagic Type:  ☐ Early  ☐ Late

*Ordinary type: Raised, pustular lesions with 3 sub-types:
   Confluent: Confluent rash on face and forearms
   Semi-confluent: Confluent rash on face, discrete elsewhere
   Discrete: Areas of normal skin between pustules, even on face

Modified type: Like ordinary type but with an accelerated course

6. DATE LAST SCAB FELL OFF:   Month  Day  Year

7. COMPLICATIONS (Check all that apply).
   Skin Secondary bacterial infection:  ☐ Yes  ☐ No  ☐ Unknown
   Ocular corneal ulcer or keratitis:  ☐ Yes  ☐ No  ☐ Unknown
   CNS encephalitis:  ☐ Yes  ☐ No  ☐ Unknown
   Respiratory:  ☐ Bronchitis  ☐ Yes  ☐ No  ☐ Unknown
   Respiratory:  ☐ Pneumonia  ☐ Yes  ☐ No  ☐ Unknown
   Joint/Bones:  ☐ Arthralgia  ☐ Yes  ☐ No  ☐ Unknown
   Joint/Bones:  ☐ Osteitis  ☐ Yes  ☐ No  ☐ Unknown
   Hemorrhagic:  ☐ Yes  ☐ No  ☐ Unknown
   Shock:  ☐ Yes  ☐ No  ☐ Unknown
   Other, please specify: ____________________________________________________

8. ANTIVIRAL MEDICATION: CIDOFOVIR  ☐ Yes  ☐ No  ☐ Unknown

   OTHER ANTIVIRAL MEDICATIONS, SPECIFY: ______________________________________________________________________________________

9. SMALLPOX VACCINATION HISTORY
   WAS THE CASE VACCINATED SINCE THE COMPLETION OF FORM 1A?  ☐ Yes  ☐ No  ☐ Unknown
   DATE:   Month  Day  Year  
   VACCINE “TAKE”Recorded at 7 Days?  ☐ Yes  ☐ No  ☐ Unknown

Clinical Course Disposition

10. DATE OF HOSPITAL DISCHARGE:   Month  Day  Year

    COMPLICATIONS AT DISCHARGE:  ☐ Yes  ☐ No  ☐ Unknown

    IF YES, PLEASE SPECIFY: ____________________________________________________