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: ______________________
____

Public reporting burden of this collection of information is estimated to average 30 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-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

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.				
Sweats	☐ Yes	☐ No	☐ Unk.	Headache	☐ Yes	☐ No	☐ Unk.
Chills	☐ Yes	☐ No	☐ Unk.	Dyspnea	☐ Yes	☐ No	☐ Unk.
Nausea/Vomiting	☐ Yes	☐ No	☐ Unk.	Diarrhea	☐ Yes	☐ No	☐ Unk.
Malaise	☐ Yes	☐ No	☐ Unk.	Myalgia	☐ Yes	☐ No	☐ Unk.
Abdominal pain	☐ Yes	☐ No	☐ Unk.	Backache	☐ 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#_____________**