Ongoing U.S. Mpox Outbreak
Short Case Report Form

Instructions for State, Local, and Territorial Health Jurisdictions: This form is an aid for public health officials when collecting essential data elements needed for investigating and reporting probable or confirmed mpox cases to CDC as part of the ongoing U.S. Mpox Outbreak response. Local public health officials may choose to use this fillable PDF for data collection within their jurisdiction, but data submission to CDC should be through established case surveillance systems and not through individually completed forms. Case information should always be captured electronically to minimize transcription errors; however, this form may be printed if needed.

Please visit the CDC Website for the latest public health information about mpox: www.cdc.gov/poxvirus/mpox

Note: This form is to be administered to the patient or their proxy–if the patient is deceased, administer with their proxy and/or healthcare provider.

State-assigned case ID:

Additional ID: *(Optional, if needed for cross-referencing NNDSS and DCIPHER Case IDs)*

State/Territory of Residence:

If you reside in a Tribal Area, please specify:

County of Residence:

[FOR INTERVIEWER] Did the individual die from this illness?

◯ **Yes** ◯ **No** ◯ **Unknown**

If deceased, date of death:

Demographic Information

What is your age, in years?

What is your race?

- ☐ **White**
- ☐ **African American or Black**
- ☐ **Asian**
- ☐ **Native Hawaiian/Pacific Islander**
- ☐ **American Indian/Alaska Native**
- ☐ **Unknown Race**
- ☐ **Other _____**
- ☐ **Declined to answer**

If the selected race is American Indian or Alaska Native, what is the tribal affiliation?

What is your ethnicity?

- ◯ Hispanic or Latino
- ◯ Non-Hispanic or Latino
- ◯ Declined to answer
- ◯ Unknown

How do you currently describe yourself?

- ☐ Male / Man / Boy
- ☐ Female / Woman / Girl
- ☐ Transgender Female / Male-to-Female (MTF) / Trans Woman / Trans Girl
- ☐ Transgender Male / Female-to-Male (FTM) / Trans Man / Trans Boy
- ☐ Another gender identity (for example: Non-binary, genderqueer, two spirit)
- ☐ Declined to answer
- ☐ Unknown

If you selected another gender identity, please specify:

What sex were you assigned at birth (for example: sex listed on original birth certificate)?

◯ Male ◯ Female ◯ Declined to answer ◯ Unknown

Which of the following best represents how you think of yourself?

- ☐ Gay, lesbian, or same-gender loving
- ☐ Straight
- ☐ Bisexual
- ☐ I use a different term (for example: asexual, queer)
- ☐ Questioning, unsure, don't know
- ☐ Declined to answer
- ☐ Unknown

If you use another term, please specify:

[FOR INTERVIEWER] Is this individual a health care worker who was exposed at work?

◯ Yes ◯ No ◯ Unknown

[FOR INTERVIEWER] Did the subject receive a vaccine against mpox/smallpox since May of 2022?

◯ Yes ◯ No ◯ Unknown

If yes, please indicate dose number received and corresponding vaccine date:

Vaccine Date (if specific date is not known, enter 1/1/YEAR)	Vaccine Dose Number
___/___/_____ OR ◯ Vaccine date is unknown	
___/___/_____ OR ◯ Vaccine date is unknown	
___/___/_____ OR ◯ Vaccine date is unknown	

History of Possible Exposures

[FOR INTERVIEWER] Specify if this case is epidemiologically linked to another confirmed or probable case: If yes, please provide Case ID(s) (if known):

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, please provide CDC assigned Case ID. Enter International if not a U.S. Case, or enter "unknown" if unknown

If yes, please provide State assigned Case ID.

Specify the mechanism by which the disease was acquired (transmission mode) (select all that apply):

- ☐ **Animal to human transmission**
- ☐ **Droplet transmission**
- ☐ **Indeterminate transmission**
- ☐ **Nosocomial transmission**
- ☐ **Sexual transmission**
- ☐ **Transdermal transmission** (skin to skin contact)

Travel

If you spent time in a country outside the U.S. during the 3 weeks before your first symptom appeared (also called symptom onset), please report country of exposure:

Country traveled to:

[FOR INTERVIEWER] Please provide the suspect location of exposure:

◯ **International** ◯ **Domestic** ◯ **Air Travel Contact** ◯ **Other** ◯ **Unknown**

[FOR INTERVIEWER] If other, please specify the suspect location of exposure:

Diagnostic Testing Information

Performing lab specimen ID:

What Laboratory performed testing?

- LRN Member Lab
- Commercial Lab
- Academic/Hospital
- Unknown

If commercial lab or academic/hospital lab, please specify name of laboratory:

Test result date:

Was specimen tested for clade designation?

- In process
- Yes (complete)
- No
- Unknown

If "yes (complete)" clade results:

- Clade II
- Clade I
- Indeterminate

Performing lab specimen ID:

What Laboratory performed testing?

- LRN Member Lab
- Commercial Lab
- Academic/Hospital Lab
- Unknown

If commercial lab or academic/hospital lab, please specify name of laboratory:

Test result date:

Was specimen tested for clade designation?

- In process
- Yes (complete)
- No
- Unknown

If "yes (complete)" clade results:

- Clade II
- Clade I
- Indeterminate

Clinical

What day was the date of your illness onset (the date any symptom first started)?

[FOR INTERVIEWER] What is the individual's HIV status?

- HIV Positive
- HIV Negative
- Unknown

Has the individual been hospitalized for mpox?

- Yes
- No
- Unknown

Individual's most recent admission date to the hospital for the condition covered by the investigation:

Individual's most recent discharge date from the hospital for the condition covered by the investigation:

Are you currently pregnant?

○ **Yes** ○ **No** ○ **Unknown**

Are you currently breastfeeding?

○ **Yes** ○ **No** ○ **Unknown**

Does this case have a history of previous mpox illness?

Please note: a new case of mpox virus infection must meet the following criteria:

1. Healthy tissue has replaced the site of all previous lesions after they have scabbed and fallen off; **AND**
2. New lesions are present which have tested positive for orthopoxvirus or mpox virus DNA by molecular methods or genomic sequencing

○ **Yes** ○ **No** ○ **Unknown**

If yes, date of prior infection:

[FOR INTERVIEWER] Please use this space to include any additional notes or comments.