

TYPHOID FEVER SURVEILLANCE REPORT

CDC NO.:
(1-5)

Form Approved OMB No. 0920-0009

Instructions:

– Please complete this form only for new, symptomatic, culture-proven cases of typhoid fever. –

DEMOGRAPHIC DATA

1. Reporting State: <input type="text"/> <input type="text"/> (6-7)	2. First three letters of patient's last name: <input type="text"/> <input type="text"/> <input type="text"/> (8-10)	3. Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (11-16) Mo. Day Yr.	or Age: <input type="text"/> <input type="text"/> (in years) (17-18)
4. Sex: (19) 1 Male 2 Female	5. Does the patient work as a foodhandler? (20) 1 Yes 0 No 9 Unk.	6. Citizenship: (21) 1 U.S. 8 Other: _____ 9 Unk.	

CLINICAL DATA

7. Was the patient ill with typhoid fever? (fever, abdominal pain, headache, etc) (22) 1 Yes 0 No 9 Unk.	<i>If Yes, give date of onset of symptoms:</i> <input type="text"/> <input type="text"/> <input type="text"/> (23-28) Mo. Day Yr.	8. Was the patient hospitalized? (29) 1 Yes 0 No 9 Unk.	<i>If Yes, how many days was the patient hospitalized?</i> <input type="text"/> <input type="text"/> (30-31) Days	9. Outcome of case: (32) 1 Recovered 2 Died 9 Unk.
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LABORATORY DATA

10. Date <i>Salmonella typhi</i> first isolated: <input type="text"/> <input type="text"/> <input type="text"/> (33-38) Mo. Day Yr.	Site(s) of isolation: (check all that apply) (39) 1 Blood 2 Stool 3 Gall bladder 8 Other (specify): _____ (40-55)
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11. Was antibiotic sensitivity testing performed on this (these) isolate(s) at the laboratory? (Please contact the clinical laboratory for this information) (56) 1 Yes 0 No 9 Unk.	<i>If Yes, was the organism resistant to:</i>	• Ampicillin:(57) 1 Yes 0 No 9 Not tested	• Chloramphenicol:(58) 1 Yes 0 No 9 Not tested	• Trimethoprim-sulfamethoxazole:(59) 1 Yes 0 No 9 Not tested	• Fluoroquinolones (e.g., Ciprofloxacin):.....(60) 1 Yes 0 No 9 Not tested
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EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? (two or more cases of typhoid fever associated by time and place) (61) 1 Yes 0 No 9 Unk.
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13. Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness? (62) 1 Yes 0 No 9 Unk.	<i>If Yes, indicate type of vaccine received:</i>	• Standard killed typhoid shot (Wyeth-Ayerst):(63) 1 Yes 0 No 9 Unk. <input type="text"/> <input type="text"/> (64-65) Year received:	• Oral Ty21a or Vivotif (Berna) four pill series:.....(66) 1 Yes 0 No 9 Unk. <input type="text"/> <input type="text"/> (67-68)	• ViCPS or Typhim Vi shot (Pasteur Merieux):(69) 1 Yes 0 No 9 Unk. <input type="text"/> <input type="text"/> (70-71)
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14. Did the patient travel or live outside the United States during the 30 days before the illness began? (72) 1 Yes 0 No 9 Unk.	<i>If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States)</i>	Date of most recent return or entry to the United States:
	1. _____ (73-88) 2. _____ (89-104)	3. _____ (105-120) 4. _____ (121-136) <input type="text"/> <input type="text"/> <input type="text"/> (137-142) Mo. Day Yr.

15. Was the purpose of the international travel:	d.) Immigration to U.S.?(146) 1 Yes 0 No 9 Unk.
a.) Business?(143) 1 Yes 0 No 9 Unk.	e.) Other?(147) 1 Yes 0 No 9 Unk.
b.) Tourism?(144) 1 Yes 0 No 9 Unk.	(if other, specify): _____ (148-164)
c.) Visiting relatives or friends?(145) 1 Yes 0 No 9 Unk.	

16. Was the case traced to a typhoid carrier?(165) 1 Yes 0 No 9 Unk.	<i>If Yes, was the carrier previously known to the health department?</i> 1 Yes 0 No 9 Unk. (166)
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17. Comments:

18. Name of Person Completing Form: _____
Address: _____
Telephone: _____ **Date:** _____
Mo. Day Yr.

– THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM –

Please send a copy to your STATE EPIDEMIOLOGY OFFICE and the
FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION,
Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205

Public reporting burden of this collection of information is estimated to average 20 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 (0920-0009).