

Patient's Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_

Detach before sending to CDC



DEPARTMENT OF HEALTH & HUMAN SERVICES  
 Centers for Disease Control and Prevention (CDC)  
 P.O. Box 2087  
 Ft. Collins, CO 80522-2087



Form Approved  
 OMB No. 0920-0004

Date of Report: Mo. Day Year  
 [ ][ ] [ ][ ] [ ][ ][ ][ ]

## PLAGUE CASE INVESTIGATION REPORT

### - PATIENT DEMOGRAPHICS -

State: _____		County: _____		Zip: _____		Date Hospitalized Mo. Day Year [ ][ ] [ ][ ] [ ][ ][ ][ ]	
Age: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified	Patient Ethnicity: (select one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk <input type="checkbox"/> Not Hispanic or Latino		Patient Race: (select all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unk <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other			
Person making call: _____				Person taking call: _____			
Agency: _____				Agency: _____			
Phone No.: ( ) _____				Phone No.: ( ) _____			

Has local health department been notified?  Yes  No  
 If yes, give name and address of person contacted: \_\_\_\_\_

Physician(s): \_\_\_\_\_ Phone(s): ( ) \_\_\_\_\_  
 \_\_\_\_\_ ( ) \_\_\_\_\_

City: \_\_\_\_\_ Hospital: \_\_\_\_\_ Phone(s): ( ) \_\_\_\_\_

### - ILLNESS -

Date of onset of illness: Mo. Day Year [ ][ ] [ ][ ] [ ][ ][ ][ ]  
 Symptoms: \_\_\_\_\_

**SIGNS:** Temperature: \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ Date: Mo. Day Year [ ][ ] [ ][ ] [ ][ ][ ][ ]

Bubo:  Inguinal  Femoral  Other  
 Cervical  Axillary \_\_\_  R \_\_\_  L  
 Size (cm) describe: \_\_\_\_\_ Tender:  Yes  No Erythema:  Yes  No

Skin Ulcer:  Yes  No Location: \_\_\_\_\_  
 Insect Bite(s):  Yes  No Location: \_\_\_\_\_

Cough:  Yes  No Date of onset of cough: Mo. Day Year [ ][ ] [ ][ ] [ ][ ][ ][ ]  
 Cough productive:  Yes  No

Current condition and prognosis: \_\_\_\_\_

**OUTCOME:**  Survived  Died Discharge Date: Mo. Day Year [ ][ ] [ ][ ] [ ][ ][ ][ ] Autopsy:  Yes  No

Public reporting burden of this collection of information is estimated to average 15 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, Project Clearance Officer, 1600 Clifton Road, MS E-71, Atlanta, GA 30333, ATTN: PRA (0920-0004). Do not send the completed form to this address.

**- LABORATORY -**

<b>Chest X-ray:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Pneumonia:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Date :</b> Mo.   Day   Year <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
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<b>WBC Count:</b> _____	<b>Left Shift:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Bands:</b> _____	<b>Polys:</b> _____
<b>Lymph:</b> _____	<b>Mono:</b> _____	<b>Eos:</b> _____	<b>Bas:</b> _____

**Bacteria on blood smear?**  
 Yes    No    Don't know \_\_\_\_\_

**Blood cultures taken?**  
 Yes    No   How many? \_\_\_\_\_ Results? \_\_\_\_\_

<b>Bubo Aspirate:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	<table style="width:100%;"> <tr> <td></td> <td align="center">POS.</td> <td align="center">NEG.</td> </tr> <tr> <td>Gram Stain .....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Wayson Strain .....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>(or Wright's, Giemsa)</td> <td></td> <td></td> </tr> <tr> <td>FA (Plague) .....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Culture .....</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>		POS.	NEG.	Gram Stain .....	<input type="checkbox"/>	<input type="checkbox"/>	Wayson Strain .....	<input type="checkbox"/>	<input type="checkbox"/>	(or Wright's, Giemsa)			FA (Plague) .....	<input type="checkbox"/>	<input type="checkbox"/>	Culture .....	<input type="checkbox"/>	<input type="checkbox"/>
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**Serologies:**

S <sub>1</sub> result: _____	Date Serum Drawn: _____
S <sub>2</sub> result: _____	Date Serum Drawn: _____

**- ANTIBIOTICS -**

Treatment	Date Started	Date Stopped	Dosage & Schedule
	Mo.   Day	Mo.   Day	
1. _____	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 20px;"></div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 20px;"></div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div>	1. _____
2. _____	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 20px;"></div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 20px;"></div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div>	2. _____
3. _____	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 20px;"></div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 20px;"></div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div>	3. _____

**Isolation:**    Respiratory    Wound precautions only    None

**- EPIDEMIOLOGY -**

**Whereabouts during 10 days before onset on (dates)** (Include all outdoor activities)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other persons ill after same exposure?** (Names and whereabouts):

\_\_\_\_\_

\_\_\_\_\_

**Did patient handle sick or dead rodents, rabbits, or other animals?**    Yes    No   If so, where? \_\_\_\_\_

<b>Patient recall flea or other insect bites?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Wild animal contact, including hunting?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Contact with human plague patient?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Contacts or relatives who died in past week?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Pets</b> (kind and number) _____	<b>Illness in pets?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____	<b>Pets free roaming?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
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**- EPIDEMIOLOGY (Continued) -**

<b>(Community Contacts During Illness)</b> <b>NAME*</b>	<b>(Setting and Circumstances)</b> <b>LOCATION and TIME</b>	<b>DATE</b> (mm, dd, yyyy)
<b>(a) Family and Household</b>		
		___/___/___
		___/___/___
		___/___/___
		___/___/___
		___/___/___
<b>(b) Work or School</b>		
		___/___/___
		___/___/___
		___/___/___
		___/___/___
		___/___/___
<b>(c) Friends/acquaintances</b>		
		___/___/___
		___/___/___
		___/___/___
		___/___/___
		___/___/___
<b>(d) Hospital</b>		
		___/___/___
		___/___/___
		___/___/___
		___/___/___

\*When a group too large to list is involved, the location, setting, time, and date will allow relevant persons to be traced (e.g., church, school, social activities, etc.)

**To carry out field investigation in the home or work area, it would be helpful to get permission to enter and work on private property.**

**Who should be contacted for such permission?**

Name: \_\_\_\_\_ Phone No.: ( \_\_\_\_\_ ) \_\_\_\_\_  
(Area Code)