27. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply or if NONE or CHART UNAVAILABLE, check appropriate box) 1 None 1 Unknown

- AIDS or CD4 count <200
- Alcohol Abuse, Current
- Alcohol Abuse, Past
- Asthma
- Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
- Bone Marrow Transplant (BMT)
- Cerebral Vascular Accident (CVA)/Stroke/TIA
- Chronic Kidney Disease
- Chronic Liver Disease/cirrhosis
- Current Chronic Dialysis
- Chronic Skin Breakdown
- Cochlear Implant

- Complement Deficiency
- Connective Tissue Disease (Lupus, etc.)
- CSF Leak
- Deaf/Profound Hearing Loss
- Dementia
- Diabetes Mellitus
- Emphysema/COPD
- Heart Failure/CHF
- HIV Infection
- Hodgkin’s Disease/Lymphoma
- Immunoglobulin Deficiency
- Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)
- VDU, Current
- VDU, Past
- Leukemia
- Multiple Myeloma
- Multiple Sclerosis
- Nephrotic Syndrome
- Neuromuscular Disorder
- Obesity
- Other Drug Use, Current
- Other Drug Use, Past
- Parkinson’s Disease
- Peptic Ulcer Disease
- Peripheral Neuropathy
- Peripheral Vascular Disease
- Plegias/Paralysis
- Premature Birth (specify gestational age at birth) [wks]
- Seizure/Seizure Disorder
- Sickle Cell Anemia
- Smoker (current)
- Solid Organ Malignancy
- Solid Organ Transplant
- Splenectomy/Asplenia
- Other prior illness (specify):

**IMPORTANT – PLEASE COMPLETE FOR THE RELEVANT ORGANISM –**

### HAEMOPHILUS INFL UENZAE

28a. What was the serotype? 1 b 2 Not Typeable 3 a 4 c 5 d 6 e 7 f 8 Other (specify) 9 Not Tested or Unknown

28b. If <15 years of age and serotype ‘b’ or ‘unknown’ did patient receive Haemophilus influenzae b vaccine? If YES, please complete the list below.

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<th>DOSE</th>
<th>DATE GIVEN</th>
<th>VACCINE NAME</th>
<th>MANUFACTURER</th>
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**GROUP B STREPTOCOCCUS**

31b. If survived, did patient have any of the following sequelae evident upon discharge? (Check all that apply) 1 None 1 Unknown

- Hearing deficits
- Amputation (digit)
- Amputation (limb)
- Seizures
- Paralysis or spasticity
- Skin Scarring/necrosis
- Other (specify)

32. Was case first identified through audit? 1 Yes 2 No 9 Unknown

33. Did the patient have surgery or any skin incision? 1 Yes 2 No 9 Unknown

34. Did the patient deliver a baby (vaginal or C-section)? 1 Yes 2 No 9 Unknown

35. Did patient have:

- 1 Varicella
- 1 Penetrating trauma (post operative)
- 1 Blunt trauma
- 1 Burns

36. COMMENTS:

Public reporting burden of this collection of information is estimated to average 10 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 information, including suggestions for reducing this burden to CDC.

CDC/ATS/DR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30329, ATTN: PRA(0920-0978). Do not send the completed form to this address.

37. Was case first identified through audit? 1 Yes 2 No 9 Unknown

38. Does this case have recurrent disease with the same pathogen? 1 Yes 2 No 9 Unknown

39. S.O. Initials