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Form approved
OMB No. 0920-0009

CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Demographic data:

Patient's name (first 4 letters of last name): _____ **Sex:** ☐ Male ☐ Female

State of residence: _____ **County:** _____ **Age:** ____ **Date of birth** (mm/yyyy): _____

Ethnic origin:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race *(check all that apply):*
☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Unknown

Physician's name: _____

Phone: _____ **FAX:** _____ **Email:** _____

Clinical data: *(For dates, be as specific as possible. However, approximations [e.g., mm/yyyy] are okay.)*

Date of onset of illness / symptoms: _____ (☐ Unknown date; unable to approximate)

Signs and symptoms:

Diarrhea: ☐ Yes ☐ No ☐ Unknown
If yes, maximum number stools per day: _____ *(unknown = 999)*

Weight loss: ☐ Yes ☐ No ☐ Unknown
If yes, baseline weight: _____ lbs. *(unknown = 999)*
Number of pounds lost: _____

Fever (or felt feverish): ☐ Yes ☐ No ☐ Unknown
If yes, temperature: _____degrees F *(unknown or not measured = 999)*

Fatigue:	☐ Yes	☐ No	☐ Unknown
Anorexia:	☐ Yes	☐ No	☐ Unknown
Nausea:	☐ Yes	☐ No	☐ Unknown
Vomiting:	☐ Yes	☐ No	☐ Unknown
Abdominal cramps:	☐ Yes	☐ No	☐ Unknown

Other symptoms *(specify):* _____

Hospitalized *(at least overnight)*: ☐ Yes ☐ No ☐ Unknown
If yes, name of hospital: _____ Date of admission: _____

Date stool collected for *Cyclospora* testing: _____ *(If multiple stools, specify below or on p. 2.)*

Test results: ☐ Positive ☐ Negative ☐ Unknown (or pending)

If known, specify testing methods and laboratories, including, if applicable, testing done by state or CDC labs:

_____

Results from **state lab** (not applicable: ☐):	☐ Positive	☐ Negative	☐ Unknown (or pending)
Results from **CDC lab** (not applicable: ☐):	☐ Positive	☐ Negative	☐ Unknown (or pending)

Has the case-patient been treated (or is he/she being treated) for cyclosporiasis? ☐ Yes ☐ No ☐ Unknown
If yes, what medication(s)? ☐ Trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)
☐ Other *(specify):* _____
☐ Unknown

Is case-patient allergic to (or intolerant of) sulfa drugs? ☐ Yes ☐ No ☐ Unknown

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Exposures during 2 weeks before onset of illness:

(For dates, be as specific as possible. However, approximations [e.g., mm/yyyy] are okay.)

History of travel *(during **2 weeks** before onset of illness)*: ☐ Yes ☐ No ☐ Unknown

International travel **(country):** **(☐ Unknown dates of travel and unable to approximate)**

(1) _____ Departure date: _____ Return date: _____
(2) _____ Departure date: _____ Return date: _____
(3) _____ Departure date: _____ Return date: _____

U.S. travel **(state):** **(☐ Unknown dates of travel and unable to approximate)**

(1) _____ Departure date: _____ Return date: _____
(2) _____ Departure date: _____ Return date: _____
(3) _____ Departure date: _____ Return date: _____

Fresh produce exposures *(produce **eaten or tasted** during **2 weeks** before onset of illness)*:

Fresh berries: ☐ Yes (*If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Strawberries ☐ Blackberries ☐ Blueberries
☐ Raspberries ☐ Black raspberries ☐ Golden raspberries ☐ Unknown type of berry
☐ Other types of berries *(specify)*: _____

Fresh herbs: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Cilantro ☐ Oregano ☐ Thyme ☐ Mint ☐ Dill ☐ Parsley ☐ Rosemary
☐ Basil *(specify types):* ☐ Sweet basil ☐ Thai basil *(i.e., green leaves and purple stems)*
☐ Purple basil *(i.e., purple leaves and stems)*
☐ Other types of herbs *(specify)*: _____
☐ Unknown type of herb

Lettuce: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Mesclun (a.k.a., spring mix, field greens, baby greens, & gourmet salad mix)
☐ Arugula
☐ Other types of lettuce *(specify)*: _____
☐ Unknown type of lettuce

Other types of fresh produce: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Fruit, other than berries *(specify types)*: _____
☐ Snow peas *(flat, shiny pea pods containing tiny peas)*
☐ Other types of fresh produce *(specify)*: _____
☐ Unknown type of fresh produce

Did the case-patient attend any events (e.g., wedding reception) *(during **2 weeks** before onset of illness)?*
☐ Yes ☐ No ☐ Unknown
If yes, specify type of social or other event: _____ Event date: _____

Does the case-patient know of other ill persons? ☐ Yes ☐ No ☐ Unknown
If yes, did health department obtain contact information and investigate further *(provide comments below)*?
☐ Yes ☐ No ☐ Under consideration (or pending) ☐ Unknown

Comments and additional data: Change Text Size

Name *(person filling out form):* _____ **Title:** _____
Phone: _____ **FAX:** _____ **Email:** _____
Name of investigating health department: _____ **Date form submitted:** _____

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