CDC 2019-nCoV ID: ☐

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

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State: _____ Case state/local ID: _____

State/local health dept.: _____ CDC 2019-nCoV ID: _____

Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

State/local Specimen IDs: _____ _____ _____ _____ _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case 0023CA has contacts 0023CA-01 and 0023CA-02

b. For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____

Telephone _____ Email _____

Date of interview: _____(MM/DD/YYYY) Date of medical chart abstraction: _____ (MM/DD/YYYY)

Basic case information

Report date to CDC (MM/DD/YYYY):
____/_____/_____

Is this a 2019-nCoV laboratory-confirmed case?
☐ Yes
☐ No (if no, do not complete this form)

Race (check all that apply):
☐ White
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Other, specify: _____
☐ Asian
☐ Black
☐ Unknown

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1
___/___/___ (MM/DD/YYYY)

If yes, discharge date 1
__/___/____ (MM/DD/YYYY)

Date of first positive specimen collection (MM/DD/YYYY):
____/_____/_____
☐ Unknown

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Not specified

Date of birth (MM/DD/YYYY): ____/_____/____

Age: _____

Age units(yr/mo/day): _____

Sex:
☐ Male ☐ Female
☐ Other ☐ Unknown

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown

If yes, total days with MV (days)
_____

Symptom status (ever):
☐ Symptomatic
☐ Asymptomatic
☐ Unknown

If symptomatic, onset date (MM/DD/YYYY):
____/_____/_____
☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY): ____/_____/_____
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
☐ Travel to Wuhan
☐ Travel to Hubei
☐ Travel to mainland China
☐ Travel to other non-US country
☐ Household contact with another lab-confirmed 2019 nCoV case-patient
☐ Community contact with another lab-confirmed 2019 nCoV case-patient
☐ Healthcare contact with another lab-confirmed 2019 nCoV case-patient
☐ Patient ☐ Visitor ☐ HCW
☐ Animal exposure
☐ Other, specify:_____
☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY):
____/_____/_____
☐ Unknown date of death

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Patient interview

Who is providing information for this form?

☐ Case-patient ☐ Other, specify relationship to case:_____

Case-patient's primary language: _____ Was this form administered via a translator? □ Yes □ No □ Unknown

Case-patient demographic information

1. Was this case a known patient under investigation (PUI) prior to lab confirmation? ☐ Yes ☐ No ☐ Unknown
2. Under what process was the case first identified? (check all that apply): ☐ PUI ☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX notification of travelers; if checked, DGMQID_____ ☐ Unknown ☐ Other, specify:_____
3. County of Residence:_____ State of Residence:_____
4. Current status: ☐ Hospitalized for clinical purposes ☐ Hospitalized for isolation ☐ Home isolation
5. Occupation:_____
   If student, what grade level? _____
   If child, does s/he attend day care? ☐ Yes ☐ No

Symptoms, clinical course, past medical history and social history

6. During this illness, did you experience any of the following symptoms?

Symptom	Symptom Present?
Systemic	
Fever >100.4F (38C)	☐Yes ☐No ☐Unk
Highest temp_____ °F	
Date of onset (MM/DD/YYYY) ___/___/_____	
Duration of fever >100.4F (38C) (days) _____	_____
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk
Chills	☐Yes ☐No ☐Unk
Dehydration	☐Yes ☐No ☐Unk
Fatigue	☐Yes ☐No ☐Unk
Muscle aches (myalgia)	☐Yes ☐No ☐Unk
Rash	☐Yes ☐No ☐Unk
Head, Eyes, Ears, Nose, Throat	
Headache	☐Yes ☐No ☐Unk
Eye redness (conjunctivitis)	☐Yes ☐No ☐Unk
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk
Sore throat	☐Yes ☐No ☐Unk
Respiratory	
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk
Dry	☐Yes ☐No ☐Unk
Productive	☐Yes ☐No ☐Unk
Bloody sputum (hemoptysis)	☐Yes ☐No ☐Unk
Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk
Wheezing	☐Yes ☐No ☐Unk
Apnea/abnormally long pauses of breathing	☐Yes ☐No ☐Unk
Cardiovascular	
Chest Pain	☐Yes ☐No ☐Unk
GI	
Abdominal pain	☐Yes ☐No ☐Unk
Vomiting	☐Yes ☐No ☐Unk
Nausea	☐Yes ☐No ☐Unk

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Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unk
Poor Feeding/Poor appetite	☐Yes ☐No ☐Unk
Neuro	
Seizures	☐Yes ☐No ☐Unk
Other	
Other, specify:	☐Yes ☐No ☐Unk
Other, specify:	☐Yes ☐No ☐Unk
Other, specify:	☐Yes ☐No ☐Unk

7. Did you miss work or school for this illness? ☐ Yes ☐ No ☐ Unknown
   If yes, how many days? _____
8. Do you feel back to normal? ☐ Yes ☐ No ☐ Not applicable (patient deceased) ☐ Unknown
   If yes, when did you feel back to normal? _____/_____/_____ (MM/DD/YYYY)
9. Did you receive any medical care for the illness? ☐ Yes ☐ No ☐ Unknown
10. If yes, where and on which dates did you seek care after this illness started (check all that apply)?
    - ☐ Doctor's office — Date 1: _____/_____/_____ (MM/DD/YYYY) Date 2: _____/_____/_____ (MM/DD/YYYY)
    - ☐ Emergency room — Date 1: _____/_____/_____ (MM/DD/YYYY) Date 2: _____/_____/_____ (MM/DD/YYYY)
    - ☐ Retail store/pharmacy — Date 1: _____/_____/_____ (MM/DD/YYYY) Date 2: _____/_____/_____ (MM/DD/YYYY)
    - ☐ Health department — Date 1: _____/_____/_____ (MM/DD/YYYY) Date 2: _____/_____/_____ (MM/DD/YYYY)
    - ☐ Urgent care — Date 1: _____/_____/_____ (MM/DD/YYYY) Date 2: _____/_____/_____ (MM/DD/YYYY)
    - ☐ Other _____ — Date 1: _____/_____/_____ (MM/DD/YYYY) Date 2: _____/_____/_____ (MM/DD/YYYY)
    - ☐ Unknown
11. Were you hospitalized for the illness? ☐ Yes ☐ No ☐ Unknown
    Purpose: ☐ Clinical indication ☐ No clinical indication (e.g., isolation for public health)

Past medical history

12. Do you have any pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown
    Was the medical chart used to inform this section? ☐ Yes ☐ No

Chronic Lung Disease	☐Yes	☐No	☐Unknown	
Asthma/reactive airway disease	☐Yes	☐No	☐Unknown	
Emphysema/COPD	☐Yes	☐No	☐Unknown	
Other chronic lung disease	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Active tuberculosis	☐Yes	☐No	☐Unknown	
Diabetes Mellitus	☐Yes	☐No	☐Unknown	
Diabetes Mellitus Type 1	☐Yes	☐No	☐Unknown	
Diabetes Mellitus Type 2	☐Yes	☐No	☐Unknown	
Cardiovascular disease	☐Yes	☐No	☐Unknown	
Hypertension	☐Yes	☐No	☐Unknown	
Coronary artery disease	☐Yes	☐No	☐Unknown	
Heart failure/Congestive heart failure	☐Yes	☐No	☐Unknown	
Cerebrovascular accident/Stroke	☐Yes	☐No	☐Unknown	
Congenital heart disease	☐Yes	☐No	☐Unknown	
Other	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Renal disease	☐Yes	☐No	☐Unknown	
Chronic kidney disease/insufficiency	☐Yes	☐No	☐Unknown	
End-stage renal disease	☐Yes	☐No	☐Unknown	
Dialysis	☐Yes	☐No	☐Unknown	

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Other	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Liver disease	☐Yes	☐No	☐Unknown	
Alcoholic hepatitis	☐Yes	☐No	☐Unknown	
Chronic liver disease	☐Yes	☐No	☐Unknown	
Cirrhosis/End stage liver disease	☐Yes	☐No	☐Unknown	
Hepatitis B, chronic	☐Yes	☐No	☐Unknown	
Hepatitis C, chronic	☐Yes	☐No	☐Unknown	
Non-alcoholic fatty liver disease (NALFD)/NASH	☐Yes	☐No	☐Unknown	
Other	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Immunocompromised Condition	☐Yes	☐No	☐Unknown	
AIDS or CD4 count <200	☐Yes	☐No	☐Unknown	
HIV infection	☐Yes	☐No	☐Unknown	
Solid organ transplant	☐Yes	☐No	☐Unknown	
Stem cell transplant (e.g., bone marrow transplant)	☐Yes	☐No	☐Unknown	
Cancer: current/in treatment of diagnosed in last 12 months	☐Yes	☐No	☐Unknown	
Other	☐Yes	☐No	☐Unknown	(If YES, specify)
Neurologic/neurodevelopmental disorder	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐No	☐Unknown	(If YES, specify) _____

13. Current height: _____ (inches) OR _____ (cm)
14. Current weight: _____ (pounds) OR _____ (kg)
15. If female, are you currently pregnant? ☐ Yes Weeks pregnant at onset_____ ☐ No ☐ Unknown
16. If female, are you postpartum (12 months postpartum or less)? ☐ Yes ☐ No ☐ Unknown
17. If female, are you breastfeeding? ☐ Yes ☐ No ☐ Unknown
18. If child, is he/she being breastfed? ☐ Yes ☐ No ☐ Unknown

Social history

19. Do you currently smoke cigarettes? ☐ Yes ☐ No ☐ Unknown
    If yes, how many packs of cigarettes per day? _____ For how many years? _____
20. Have you ever smoked cigarettes? ☐ Yes ☐ No ☐ Unknown
    If yes, how many packs of cigarettes per day? _____ For how many years? _____ How long since you last smoked a cigarette? ___(m) ___(y)
21. Do you currently use e-cigarettes/vape-pen? ☐ Yes ☐ No ☐ Unknown
22. In the past year, how often did you have a drink containing alcohol?
    ☐ Never ☐ Monthly or less ☐ 2-4 times a month
    ☐ 2-3 times per week ☐ 4 or more times per week

Travel history

23. In the 14 days prior to illness onset, were you traveling away from your home (domestic and international)?
    ☐ Yes ☐ No (skip to Q. 25) ☐ Unknown (skip to Q.25)
24. Where did you travel 14 days prior to illness onset (list **ALL** locations, including overnight transits and layovers)?

	Departure Date (MM/DD/YYYY)	Departure city, state/province/country	Arrival Date (MM/DD/YYYY)	Arrival city, state/province/country
Trip 1				
Trip 2				
Trip 3				

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Trip 4				
Trip 5				

Exposure history

25. In the 14 DAYS prior to illness, did you have close contact with another lab-confirmed 2019-nCoV case-patient?

☐ Yes ☐ No ☐ Unknown

If yes, please fill out the "Household/Close Contact Investigation Form".

26. Relationship to 2019-nCoV **source** case (select all that apply):
☐ Spouse/Partner ☐ Child ☐ Parent ☐ Other Family ☐ Friend ☐ HCW ☐ Co-worker
☐ Classmate ☐ Roommate ☐ Contact only – no relationship ☐ Other (specify):_____

27. Exposure setting to the 2019-nCoV **source** case (select all that apply):
☐ Household ☐ Work ☐ Daycare ☐ School/University ☐ Transit ☐ Rideshare ☐ Hotel
☐ Healthcare ☐ Other (specify): _____

28. In the 14 DAYS prior to illness onset, did you…

Exposure	**Answer**	**Date Range**
…have any household members, friends, acquaintances, or co-workers who had symptoms like you?	☐ Yes ☐ No ☐ Unknown	
…have close contact (e.g. caring for, speaking with, or touching) with any ill persons?	☐ Yes ☐ No ☐ Unknown	
…attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?	☐ Yes ☐ No ☐ Unknown	
…have a household member who attended school or daycare?	☐ Yes ☐ No ☐ Unknown	
…have close contact with an ill person who had contact with a lab-confirmed 2019-nCoV case-patient (i.e., secondary contact to confirmed case)?	☐ Yes ☐ No ☐ Unknown	
…have close contact with a person who had a fever and/or acute respiratory illness and recent travel in China?	☐ Yes ☐ No ☐ Unknown	
…have close contact with a person who recently travelled in China?	☐ Yes ☐ No ☐ Unknown	
…visit a live animal market?	☐ Yes ☐ No ☐ Unknown	

29. During 14 days prior to illness onset, did you have any direct contact with any type of animals including livestock, pets, or wildlife, whether at home or away from home? (list **ALL** animal exposures including livestock, pets, and wildlife)?

☐ Yes ☐ No ☐ Unknown

City/Country contact(s) occurred	Type of animal(s) contacted (one type of animal per row)	Date(s) contact occurred (MM/DD/YYYY)	Contact setting(s) (check all that apply)
			☐ Home ☐ Work ☐ Farm ☐ Animal Market ☐ Zoo ☐ Other_____
			☐ Home ☐ Work ☐ Farm

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City/Country contact(s) occurred	Type of animal(s) contacted (one type of animal per row)	Date(s) contact occurred (MM/DD/YYYY)	Contact setting(s) (check all that apply)
			☐ Animal Market ☐ Zoo ☐ Other_____
			☐ Home ☐ Work ☐ Farm ☐ Animal Market ☐ Zoo ☐ Other_____
			☐ Home ☐ Work ☐ Farm ☐ Animal Market ☐ Zoo ☐ Other_____
			☐ Home ☐ Work ☐ Farm ☐ Animal Market ☐ Zoo ☐ Other_____

30. In the 14 DAYS prior to illness onset, did you….

Exposure	Y/N/Unk	Facility type (Select all that apply)	Date(s) exposure occurred
Work in healthcare setting:	☐ Y ☐ N ☐ Unk If yes, what was your role: ☐ Physician ☐ Nurse ☐ Administration staff ☐ Housekeeping ☐ Patient transport ☐ Other_____	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic ☐ Other (specify)	
Contact with a known 2019-nCoV case-patient in a healthcare setting	☐ Y ☐ N ☐ Unk	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic ☐ Other (specify)	
Volunteer in healthcare setting	☐ Y ☐ N ☐ Unk	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic ☐ Other (specify)	
Visit healthcare setting as a patient	☐ Y ☐ N ☐ Unk	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic ☐ Other (specify)	
Visit healthcare setting for any other reason than as a patient	☐ Y ☐ N ☐ Unk	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic ☐ Other (specify)	
Have direct patient contact	☐ Y ☐ N ☐ Unk	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	

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		☐ Home setting ☐ Other (specify)	

Outpatient chart abstraction

31. Did this patient seek medical care in an outpatient setting? ☐ Yes ☐ No ☐ Unknown
If yes, did the patient receive the following medications or were they prescribed?

Antivirals?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Antibiotics?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Bronchodilators?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
IV/IM steroids?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Inhaled steroids?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____

Hospital chart abstraction

32. If hospitalized more than once, please enter the second hospitalization's admission and discharge dates:
Admission date 2 _____/_____/_____ (MM/DD/YYYY) Discharge date 2_____/_____/_____ (MM/DD/YYYY)
33. First recorded vital signs: Temp____ °F Blood pressure: _____ Heart rate: _____ Resp rate:_____
34. Did the patient receive supplemental oxygen during hospitalization? ☐ Yes ☐ No ☐ Unknown
35. Was the patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown
ICU admission date 1 _____/_____/_____ (MM/DD/YYYY) ICU discharge date 1 _____/_____/_____ (MM/DD/YYYY)
ICU admission date 2 _____/_____/_____ (MM/DD/YYYY) ICU discharge date 2 _____/_____/_____ (MM/DD/YYYY)
36. Was the patient placed on non-invasive ventilation (BiPAP/CPAP)? ☐ Yes ☐ No ☐ Unknown
37. Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes, first MV/intub.: _____/____/_____ (MM/DD/YYYY) Total days with MV (days) ____
☐ No ☐ Unknown
Date last extubated _____/_____/_____ (MM/DD/YYYY)
38. Did the patient have ECMO?
☐ Yes, Date Start: _____/____/_____ (MM/DD/YYYY) Length of ECMO (days) ____
☐ No ☐ Unknown
39. Did the patient have a new abnormality on chest x-ray or CT scan?
☐ Yes ☐ No ☐ Chest x-ray or CT scan not performed ☐ Unknown
40. Did the patient receive a discharge diagnosis of pneumonia (refer to clinical discharge summary)?
☐ Yes ☐ No ☐ Unknown
If yes, was the determination ☐ clinical ☐ radiographic
41. Did the patient receive a discharge diagnosis of acute respiratory distress syndrome (ARDS) (refer to clinical discharge summary)?
☐ Yes ☐ No ☐ Unknown
42. Clinical Discharge Diagnoses and ICD10 Discharge Codes

Clinical Discharge Diagnoses	ICD-10-CM Code
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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43. Did the patient receive the following medications during hospitalization for this illness:

Antivirals?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Antibiotics?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Bronchodilators?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
IV/IM steroids?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Inhaled steroids?	☐ Yes	☐ No	☐ Unknown	If yes, specify _____

44. Did the patient die as a result of this illness?

☐ Yes, **Date**: _____/_____/_____ (MM/DD/YYYY) ☐ No ☐ Unknown

(If the following information is not currently available, please send an update later using death certificate or death note in hospital record.)

Contribution of 2019-novel coronavirus to death ☐ Underlying/primary ☐ Contributing/secondary ☐ No contribution to death ☐ Unknown

Was autopsy performed? ☐ Yes ☐ No ☐ Unknown

Primary Cause of death (death certificate/coroner) _____

45. To where was the patient discharged?

☐ Home ☐ Nursing facility/rehab ☐ Hospice ☐ Other _____ ☐ Unknown

Laboratory testing

46. For the following section, please complete for **ANY** specimen tested for a respiratory pathogen. Include additional sheets as needed.

Specimen Type: Nasopharyngeal swab (NP), Nasopharyngeal aspirate (NPA), Nasal aspirate, Nasal Swab, Sputum, Oropharyngeal swab (OP), Endotracheal aspirate, Chest tube fluid, Broncheoalveolar lavage specimen (BAL), Serum, Stool, Urine, Other (please specify), Unknown.

Test Type: Reverse Transcriptase-Polymerase Chain Reaction (RT-PCR), Viral/Bacterial culture, Rapid antigen test, Fluorescent antibody test (FA), Other (please specify), Unknown.

Result: Positive, Negative, Pending, Indeterminate

Specimen Collection Date (MM/DD/YYYY)	Specimen Type	Test Type	Pathogen	Result	Sent to CDC?	If sent to CDC, Specimen ID#
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

47. Any additional comments or notes?

This is the end of the case report form. Thank you very much for your time. If you have any questions please feel free to contact the CDC at 770-488-7100 or eocreport@cdc.gov