



Arizona Brucellosis Case Investigation

PATIENT

Name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Gender:  Male  Female  Unknown Pregnant:  Yes  No  Unknown

Race:  White  Black  Asian  Native American  Other: \_\_\_\_\_

Hispanic:  Yes  No  Unknown

COURSE

Date of onset: \_\_\_\_\_ If patient was hospitalized, date of admission: \_\_\_\_\_

Date of discharge: \_\_\_\_\_ Did the patient recover?  Yes  No  Unknown

Date of death: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician address: \_\_\_\_\_

MEDICAL INFORMATION

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(max Temp.: _____)  Other (list):
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Severe Malaise	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Nausea / vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Abscess	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Splenomegaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Hepatomegaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Leukopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

EPIDEMIOLOGY

Does the patient work in a livestock industry? Yes No Unknown

Occupation: \_\_\_\_\_

Exact job, type of business or industry, location:  
\_\_\_\_\_

Has the patient had any animal contact within the 6 months prior to onset of illness?

Yes No Unknown

If yes, check all species that apply: Cattle Swine Goats Sheep Dogs Cats

Other: \_\_\_\_\_

Has the patient had contact with an aborting animal? Yes No Unknown

If yes, specify: \_\_\_\_\_

Has the patient had contact with a known brucellosis infected herd of cattle or swine?

Yes No Unknown

If yes, describe: \_\_\_\_\_

Has the patient consumed unpasteurized milk? Yes No Unknown

If yes, describe: \_\_\_\_\_

Has the patient consumed any unpasteurized goat milk cheese or cheese produced in Mexico? Yes No Unknown

If yes, describe (where and from whom purchased):  
\_\_\_\_\_

Does the patient have a travel history outside of home county within 5-60 days of onset?

Yes No Unknown

If yes, document travel history:  
\_\_\_\_\_

If patient is/was pregnant, list week of gestation at onset of symptoms: \_\_\_\_\_

Outcome of pregnancy: Live birth- date: \_\_\_\_\_ Still birth- date: \_\_\_\_\_

Spontaneous abortion- date: \_\_\_\_\_ Induced abortion- date: \_\_\_\_\_

Have any household members experienced similar symptoms recently?

Yes  No  Unknown

If yes, provide details:

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**SPECIMEN TESTING**

Test	Date of collection	Date of result	Results	Laboratory
WBC:	AST:	ALT:		
Diff:	Platelets:			

**THERAPY**

Medication	Dose	Duration	Route of Administration
<input type="checkbox"/> Tetracycline			
<input type="checkbox"/> Streptomycin			
<input type="checkbox"/> Sulfonamides			
<input type="checkbox"/> Other: _____			

**COMMENTS**

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INVESTIGATOR

Investigated by: \_\_\_\_\_ Phone: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_