



**METHODS OF SUBMISSION**  
**1-Attach form to MEDSIS case**  
**OR**  
**2- Fax it to (602) 364-3198**

**CHIKUNGUNYA CASE INVESTIGATION FORM**

**PATIENT INFORMATION**

	Date of interview:	_____
Name	_____	
Date of birth/age	_____	
Address	_____	
City/state/zip	_____	
Phone	_____	
Occupation/school grade	_____	
Employer/school	_____	
Parent/guardian name	_____	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown	
Ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Race	<input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other	

**CASE INFORMATION**

MEDSIS Case#	_____
County	_____
Classification	<input type="checkbox"/> Not a case <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
Initial report date	_____
Reporter	_____
Reporter organization	_____
Reporter phone	_____
Provider name	_____
Provider organization	_____
Provider phone	_____
Onset date	_____
Diagnosis date	_____

**SYMPTOMS & OUTCOMES**

Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fever (>38C or 100F) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Max Temperature: _____
Joint Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Muscle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Extreme Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Nausea/Vomiting/Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other symptoms:	
Patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Admission date: _____
Breastfeeding a child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Breastfed child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**MEDICAL HISTORY**

Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Viral Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Diabetes Type: _____
Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Immunosuppressive Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Pulmonary Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
History of mosquito-borne illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, which one? <input type="checkbox"/> Dengue <input type="checkbox"/> Yellow Fever <input type="checkbox"/> Japanese encephalitis <input type="checkbox"/> WNV <input type="checkbox"/> SLE <input type="checkbox"/> Flavivirus	
Other past medical history chronic/infectious (including chronic or immunosuppressive conditions)	

**VACCINATION HISTORY**

Yellow Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: _____
Japanese Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: _____
Tick-borne Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: _____

**RISK FACTOR ASSESSMENT- Within 14 days of onset of symptoms:**Does the patient have known mosquito exposure? Yes No Unknown Date of exposure: \_\_\_\_\_

Exposure location: \_\_\_\_\_

Did the patient travel? (Mark the furthest destination point if there was more than one travel destination)

Yes-Outside of US Yes- Outside of Arizona Yes- Outside of county of residenceNo travel history within the past 2 weeks Unknown

TRAVEL DESTINATION	
Departure date	
Return date	
Country, city, and specific address or cross-streets of where patient stayed	

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**BLOOD AND ORGAN DONATIONS**Donate/receive blood? Yes No Unknown Date: \_\_\_\_\_Donate/receive organ tissue or transplant? Yes No Unknown Date: \_\_\_\_\_**WITHIN 30 DAYS PRIOR TO ONSET OF SYMPTOMS**Did the patient receive blood or blood products? Yes No UnknownDid the patient receive an organ or tissue transplant? Yes No Unknown**ACQUIRED**Acquired in utero? Yes No UnknownAcquired in a laboratory? Yes No UnknownAcquired occupationally (non- lab)? Yes No Unknown

Length of illness (days): \_\_\_\_\_

Date of discharge, if hospitalized: \_\_\_\_\_

Outcome:  Died Survived Unknown

Outcome description, including sequelae: \_\_\_\_\_

**TREATMENT**

Treatment Descriptions	
Notes	