



Arizona Department of Health Services

Bureau of Epidemiology & Disease Control
Office of Infectious Disease

Vector-borne & Zoonotic Disease
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Arizona Department of Health Services 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:

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: _____			

