



Respiratory Disease Cluster Case Investigation Form

Form Approved
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State: _____ Date reported to health department: ___/___/___ (MM/DD/YYYY) Date interview completed: ___/___/___ (MM/DD/YYYY)

State Epi ID: _____ State Lab ID: _____

Household ID (CDC use only): _____ CDC ID (CDC use only): _____ Cluster ID (CDC use only): _____

- At the time of this report, is the case
 Confirmed Probable Case under investigation (skip to Q.3) Not a case (skip to Q.3)
- What is the subtype?
 Influenza A(H1N1) **variant** Influenza A(H1N2) **variant** Influenza A(H3N2) **variant** Influenza A(H5N1)
 Influenza A(H7N9) Other _____ Unknown

Demographic Information

- Date of birth: ___/___/___ (MM/DD/YYYY)
- Country of usual residence: _____ If usual resident of U.S., county of residence: _____
- Race: White Asian American Indian/Alaska Native Black Native Hawaiian/Other Pacific Islander
(check all that apply)
- Ethnicity: Hispanic or Latino Not Hispanic or Latino
- Sex: Male Female

Symptoms, Clinical Course, Treatment, Testing, and Outcome

8. What date did symptoms associated with this illness start? ___/___/___ (MM/DD/YYYY)

9. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Symptom	Symptom Present?
Fever (highest temp _____ °F)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If fever present, date of onset ___/___/___ (MM/DD/YYYY)		Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Felt feverish	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If felt feverish, date of onset ___/___/___ (MM/DD/YYYY)		Eye infection/redness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

- Does the patient still have symptoms?
 Yes (skip to Q.12) No Unknown (skip to Q.12)
- When did the patient feel back to normal? ___/___/___ (MM/DD/YYYY)
- Did the patient receive any medical care for the illness?
 Yes No (skip to Q.29) Unknown (skip to Q.29)
- Where and on what date did the patient seek care (check all that apply)?
 Doctor's office **date:** ___/___/___ (MM/DD/YYYY) Emergency room **date:** ___/___/___ (MM/DD/YYYY)
 Urgent care clinic **date:** ___/___/___ (MM/DD/YYYY) Health department **date:** ___/___/___ (MM/DD/YYYY)
 Other _____ **date:** ___/___/___ (MM/DD/YYYY) Unknown
- Was the patient hospitalized for the illness?
 Yes No (skip to Q.23) Unknown (skip to Q.23)
- Date(s) of hospital admission? **First admission date:** ___/___/___ (MM/DD/YYYY) **Second admission date:** ___/___/___ (MM/DD/YYYY)
- Was the patient admitted to an intensive care unit (ICU)?
 Yes No (skip to Q.18) Unknown (skip to Q.18)
- Date of **ICU admission:** ___/___/___ (MM/DD/YYYY) Date of **ICU discharge:** ___/___/___ (MM/DD/YYYY)
- Did the patient receive mechanical ventilation / have a breathing tube?
 Yes No (skip to Q.20) Unknown (skip to Q.20)
- For how many days did the patient receive mechanical ventilation or have a breathing tube? _____ days
- Was the patient discharged?
 Yes No (skip to Q.23) Unknown (skip to Q.23)
- Date(s) of hospital discharge? **First discharge date:** ___/___/___ (MM/DD/YYYY) **Second discharge date:** ___/___/___ (MM/DD/YYYY)
- Where was the patient discharged?
 Home Nursing facility/rehab Hospice Other _____ Unknown
- Did the patient have a new abnormality on chest x-ray or CAT scan?
 No, x-ray or scan was normal Yes, x-ray or scan detected new abnormality No, chest x-ray or CAT scan not performed Unknown

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



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24. Did the patient receive a diagnosis of pneumonia?
 Yes No Unknown
25. Did the patient receive a diagnosis of ARDS?
 Yes No Unknown
26. Did the patient have leukopenia (white blood cell count <5000 leukocytes/mm³) associated with this illness?
 Normal Abnormal Test not performed Unknown
27. Did the patient have lymphopenia (total lymphocytes <800/mm³ or lymphocytes <15% of WBC) associated with this illness?
 Normal Abnormal Test not performed Unknown
28. Did the patient have thrombocytopenia (total platelets <150,000/mm³) associated with this illness?
 Normal Abnormal Test not performed Unknown
29. Did the patient experience any other complications as a result of this illness? Yes (please describe below) No Unknown

30. Did the patient receive influenza antiviral medications prior to becoming ill (within 2 weeks) or after becoming ill?
 Yes, (please complete table below) No Unknown

Drug	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)	Total number of days receiving antivirals	Dosage (if known)
Oseltamivir (Tamiflu)				mg
Zanamivir (Relenza)				mg
Other influenza antiviral _____				mg

31. Did the patient die as a result of this illness?
 Yes, **Date of death:** ____/____/____ (MM/DD/YYYY) No Unknown

Influenza Testing

32. When was the specimen collected that indicated novel influenza A virus infection by Reverse Transcription-Polymerase Chain Reaction (RT-PCR)? ____/____/____ (MM/DD/YYYY)
33. Where was the specimen collected? Doctor's office Hospital Emergency room Urgent care clinic Health department Other _____ Unknown
34. Was a rapid influenza diagnostic test (RIDT) used on any respiratory specimens collected?
 Yes No (skip to Q.38) Unknown (skip to Q.38)
35. When was the RIDT specimen collected? ____/____/____ (MM/DD/YYYY)
36. What was the result? Influenza A Influenza B Influenza A/B (type not distinguished) Negative Other _____
37. What brand of RIDT was used? _____

Medical History -- Past Medical History and Vaccination Status

38. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.
- a. Asthma/reactive airway disease Yes No Unknown
 - b. Other chronic lung disease Yes No Unknown (If YES, specify) _____
 - c. Chronic heart or circulatory disease Yes No Unknown (If YES, specify) _____
 - d. Diabetes mellitus Yes No Unknown (If YES, specify) _____
 - e. Kidney or renal disease Yes No Unknown (If YES, specify) _____
 - f. Non-cancer immunosuppressive condition Yes No Unknown (If YES, specify) _____
 - g. Cancer chemotherapy in past 12 months Yes No Unknown (If YES, specify) _____
 - h. Neurologic/neurodevelopmental disorder Yes No Unknown (If YES, specify) _____
 - i. Other chronic diseases Yes No Unknown (If YES, specify) _____
39. Does the patient frequently use a stroller or wheelchair? If yes, please describe.
 Yes _____ No Unknown
40. Was patient pregnant or ≤6 weeks postpartum at illness onset?
 Yes, pregnant (weeks pregnant at onset) _____ Yes, postpartum (delivery date) ____/____/____ (MM/DD/YYYY) No Unknown
41. Does the patient currently smoke?
 Yes No Unknown
42. Was the patient vaccinated against influenza in the past year?
 Yes No (skip to Q.45) Unknown (skip to Q.45)
43. Month and year of influenza vaccination? **Vaccination date 1:** ____/____ (MM/YYYY) **Vaccination date 2:** ____/____ (MM/YYYY)
44. Type of influenza vaccine (check all that apply): Inactivated (injection) Live attenuated (nasal spray) Unknown



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Epidemiologic Risk Factors

45. In the 7 days prior to illness onset, did the patient travel outside of his/her usual area? Yes No (skip to Q.48) Unknown (skip to Q.48)
46. When and where did the patient travel? **Please describe details of the patient's travel in the notes section at the end of the form.**
Trip 1: Dates of travel: ____/____/____ to ____/____/____ Country _____ State _____ City/County _____
Trip 2: Dates of travel: ____/____/____ to ____/____/____ Country _____ State _____ City/County _____
47. Did the patient travel in a group (check all that apply)?
 No, travelled alone Yes, with household members Yes, with non-household members Unknown

Risk Factors—Domestic and Agricultural Animals

48. In the 7 days before becoming ill, did the patient attend an agricultural fair/event or live animal market?
 Yes (specify name, if >1 fair, please describe in the notes section _____) No (skip to Q.50) Unknown (skip to Q.50)
49. In the 7 days before becoming ill, on what days did the patient attend an agricultural fair/event or live animal market (check all that apply)?
 on the day of illness onset 1 day before illness onset 2 days before illness onset 3 days before illness onset
 4 days before illness onset 5 days before illness onset 6 days before illness onset 7 days before illness onset
50. In the 7 days before becoming ill, did the patient have **DIRECT** contact with (touch or handle) any livestock animals like poultry or pigs?
 Yes No (skip to Q.53) Unknown (skip to Q.53)
51. What type(s) of animals did the patient have direct contact with (check all that apply)?
 Horses Cows Poultry/wild birds Sheep Goats Pigs/hogs Other _____
52. Where did the direct contact occur (check all that apply)?
 Home Work Agricultural fair or event Live animal market Petting zoo Other _____
53. In the 7 days before becoming ill, did the patient have **INDIRECT** contact with (walk through an area containing or come within 6 feet of) any livestock animals?
 Yes No (skip to Q.56) Unknown (skip to Q.56)
54. What type(s) of animals did the patient have indirect contact with (check all that apply)?
 Horses Cows Poultry/wild birds Sheep Goats Pigs/hogs Other _____
55. Where did the indirect contact occur (check all that apply)?
 Home Work Agricultural fair or event Live animal market Petting zoo Other _____
56. In the 7 days before becoming ill, did the patient have direct or indirect contact with any animal exhibiting signs of illness?
 Yes (specify animal type and location _____) No Unknown

Please answer Q.57–58 if ANY contact (direct, indirect, or both) with pigs/hogs identified above. If no contact identified, please skip to Q.59.

57. In the 7 days before becoming ill, on what days did the patient have **ANY** contact (direct, indirect, or both) with pigs (check all that apply)?
 on the day of illness onset 1 day before illness onset 2 days before illness onset 3 days before illness onset
 4 days before illness onset 5 days before illness onset 6 days before illness onset 7 days before illness onset
58. From Q. 57, what was the total number of different days the patient reported **ANY** pig contact (direct, indirect, or both)? _____ days
59. Does anyone else in the household own, keep or care for livestock animals?
 Yes No (skip to Q.61) Unknown (skip to Q.61)
60. What type(s) of animals are kept or cared for by household members (check all that apply)?
 Horses Cows Poultry/wild birds Sheep Goats Pigs/hogs Other _____

Risk Factors—Household, Occupational, Nosocomial, and Secondary Spread

61. Does the patient reside in an institutional or group setting (e.g. nursing home, boarding school, college dormitory)?
 Yes (skip to Q.63) No Unknown (skip to Q.63)
62. How many people resided in the patient's household(s) in the week before or after illness onset (excluding the patient)? _____

A household member is anyone with at least one overnight stay +/- 7 days from patient's illness onset, and the patient may have resided in >1 household. Please complete the table below for each household member and continue in the notes section if more space is needed.

ID	Household (HH)	Relation to patient (e.g. parent, brother, friend)	Sex (M/F)	Age	Fever or any respiratory symptom +/- 7 days from case patient's onset?	Date of illness onset	If HH member ILL		If HH member NOT ILL
							Any pig/hog contact ≤7 days before his/her onset?	Attend agricultural fair ≤7 days before his/her onset?	Pig/hog contact or fair attendance ≤10 days before patient's onset?
1	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
2	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
3	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
5	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
6	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U



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63. In the 7 days before or after becoming ill, did the patient attend or work at a child care facility?
 Yes (before becoming ill) Yes (after becoming ill) No (skip to Q.65) Unknown (skip to Q.65)
64. Approximately how many children are in the patient's class or room at the child care facility? _____
65. In the 7 days before or after becoming ill, did the patient attend or work at a school?
 Yes (before becoming ill) Yes (after becoming ill) No (skip to Q.67) Unknown (skip to Q.67)
66. Approximately how many students are in the patient's class at the school? _____ children
67. In the 7 days before or after the patient became ill, did anyone else in the patient's household(s) work at or attend a child care facility or school?
 Yes No (skip to Q.69) Unknown (skip to Q.69)
68. List ID numbers from Q.62 (the table above) for household members working at or attending a child care facility or school:

69. Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?
 Yes No Unknown
70. In the 7 days before or after becoming ill, did the patient work in or volunteer at a healthcare facility or setting?
 Yes No (skip to Q.73) Unknown (skip to Q.73)
71. Specify healthcare facility job/role:
 Physician Nurse Administration staff Housekeeping Patient transport Volunteer Other _____
72. Did the patient have direct patient contact while working or volunteering at a healthcare facility?
 Yes No Unknown
73. In the 7 days before becoming ill, was the patient in a hospital for any reason (i.e., visiting, working, or for treatment)?
 Yes No Unknown
 If yes, what were the dates? ____/____/____, ____/____/____ City/Town _____
74. In the 7 days before becoming ill, was the patient in a clinic or a doctor's office for any reason?
 Yes No Unknown
 If yes, what were the dates? ____/____/____, ____/____/____ City/Town _____
75. In the 7 days before becoming ill, did the patient have close contact (e.g. caring for, speaking with, or touching) with anyone **other than a household member** who routinely has contact with pigs/hogs?
 Yes No Unknown
76. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient's illness onset?
 Yes (**please list those ill before the case patient in the table below**) No Unknown

Relationship to patient	Sex (M/F)	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset?	Comments
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	

77. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **beginning AFTER** the case patient's illness onset?
 Yes (**please list those ill after the case patient in the table below**) No Unknown

Relationship to patient	Sex (M/F)	Age	Date of illness onset	Any pig/hog contact or fair attendance ≤7 days before his/her onset?	Comments
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	

78. Is the patient a contact of a confirmed or probable case of novel influenza A infection?
 Yes (**please list patient's confirmed or probable contacts in the table below**) No Unknown

Relationship to patient	State Epi ID	State Lab ID	Case status	Sex (M/F)	Age	Date of illness onset (MM/DD/YYYY)
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
			<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			

