v20200831

Human Infection with 2019 Novel Coronavirus Case Report Form

Fax completed form to:
DOH Disease Investigation Branch
(808) 586-4595

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

Address: _____ Phone: _____ Email: _____

Interviewer Information

Name of Interviewer: Last:	First:	Telephone:	Email:
Affiliation/Organization:			
Patient's Healthcare Provider (If different):		Telephone:	Email:

SARS-CoV-2 Testing (approved by FDA or other designated authority)

Test	Pos	Neg	Indet.	Pend.	Not Done	Specimen collection date
Molecular amplification test (RT PCR)	☐	☐	☐	☐	☐	____/____/_____
Serologic test	☐	☐	☐	☐	☐	____/____/_____
Other (specify): _____	☐	☐	☐	☐	☐	____/____/_____

Symptoms present during course of illness:
☐ Symptomatic ☐ Asymptomatic ☐ Unknown

If case was symptomatic:
Onset date (MM/DD/YYYY): ____/____/_____
☐ Unknown symptom onset date

Hospitalization, ICU, and Death Information

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown
If yes, admission date ___/___/_____ (MM/DD/YYYY) discharge date __/___/_____

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown
If yes, admission date ___/___/_____ (MM/DD/YYYY) discharge date __/___/_____

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown If yes, date of death (MM/DD/YYYY): ____/_____/_____ ☐ Unknown date

Case Demographics

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____ Age units (yr/mo/day): _____
State of residence: ____ County of residence: _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown

If female, currently pregnant?
☐ Yes ☐ No ☐ Unknown

What is the patient's occupation?
Industry: _____
Occupation: _____

Race (check all that apply):
☐ White
☐ Native Hawaiian
☐ Pacific Islander, specify: _____
☐ Japanese
☐ Filipino
☐ Chinese
☐ Other Asian, specifiy: _____
☐ Black
☐ Other, specify: _____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Unknown

Primary Language: _____

Is a translator/interpreter required?
☐ Yes ☐ No ☐ Unknown
If yes, specify which language: _____

Healthcare Worker Information

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown

If yes, what is their occupation (type of job)?
☐ Physician ☐ Respiratory therapist ☐ Other, specify: _____
☐ Nurse ☐ Environmental services ☐ Unknown

If yes, what is their job setting?
☐ Hospital ☐ Rehabilitation facility ☐ Other, specify:_____
☐ Long-term care facility ☐ Nursing home/assisted living facility ☐ Unknown

Exposure Information

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):

☐ Contact with a known COVID-19 case (probable or confirmed)
If the patient had contact with a known COVID-19 case, what type of contact?
- ☐ Household contact
- ☐ Community-associated contact
- ☐ Healthcare-associated contact (patient, visitor, or healthcare worker)

☐ Travel
- ☐ Interisland. Specify island(s): _____
- ☐ Mainland U.S. travel. Specify state(s): _____
- ☐ International travel. Specify country(s): _____
- ☐ Airport/Airplane
- ☐ Cruise ship or vessel travel as passenger or crew member. Specify name of ship: _____

☐ Congregate settings
- ☐ Workplace
- ☐ Adult congregate living facility (nursing, assisted living, or long-term care facility)
- ☐ School/university/childcare center
- ☐ Correctional facility
- ☐ Community event/mass gathering

☐ Animal with confirmed or suspected COVID-19. Specify animal: _____
☐ Other exposures, specify:_____

Which would best describe where the patient was staying at the time of illness onset?

☐ Traditional housing
- ☐ House/single family home
- ☐ Apartment

☐ Healthcare/assisted Living
- ☐ Long term care facility
- ☐ Nursing home/assisted living facility
- ☐ Acute care inpatient facility
- ☐ Rehabilitation facility

☐ Other congregate/non-traditional housing
- ☐ Homeless Shelter
- ☐ Hotel/motel
- ☐ Outside, in a car, or other location not meant for human habitation
- ☐ Correctional facility
- ☐ Mobile home
- ☐ Group home

☐ Unknown
☐ Other (specify): _____

Is this case part of an outbreak?
☐ Yes, specify outbreak name: _____ ☐ No ☐ Unknown

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Clinical course, symptoms, past medical history, and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review ☐ Other, specify:_____

Did the patient experience any of the following complications due to their illness?

Did the patient develop pneumonia?
☐ Yes ☐ No ☐ Unknown

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ No ☐ Unknown

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ No ☐ Unknown ☐ N/A, no chest X-ray done

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ No ☐ Unknown

Did the patient have an abnormal EKG?
☐ Yes ☐ No ☐ Unknown ☐ N/A, no EKG done

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days) _____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

If symptomatic, which of the following did the patient experience during their illness?

Fever ≥100.4°F (38°C)	☐Yes	☐No	☐Unk	Cough (new onset or worsening of chronic cough)	☐Yes	☐No	☐Unk
Subjective fever (felt feverish)	☐Yes	☐No	☐Unk	Shortness of breath (dyspnea)	☐Yes	☐No	☐Unk
Chills	☐Yes	☐No	☐Unk	Difficulty breathing	☐Yes	☐No	☐Unk
Muscle aches (myalgia)	☐Yes	☐No	☐Unk	Chest pain	☐Yes	☐No	☐Unk
Runny nose (rhinorrhea)	☐Yes	☐No	☐Unk	Nausea or vomiting	☐Yes	☐No	☐Unk
Sore throat	☐Yes	☐No	☐Unk	Abdominal pain	☐Yes	☐No	☐Unk
New olfactory and taste disorder(s)	☐Yes	☐No	☐Unk	Diarrhea (≥3 loose stools/24hr period)	☐Yes	☐No	☐Unk
Headache	☐Yes	☐No	☐Unk	Other, specify: _____, _____, _____	☐Yes	☐No	☐Unk
Fatigue	☐Yes	☐No	☐Unk				

Did the patient's symptoms resolve?
☐ Yes, date of symptom resolution (MM/DD/YYYY): __/__/_____
☐ Symptoms resolved, unknown date
☐ No, still symptomatic
☐ Unknown if symptoms resolved

Did they have any underlying medical conditions and/or risk behaviors? ☐Yes ☐No ☐ Unknown

Diabetes Mellitus	☐Yes	☐No	☐Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: _____	☐Yes	☐No	☐Unk
Hypertension	☐Yes	☐No	☐Unk				
Severe obesity (BMI ≥40)	☐Yes	☐No	☐Unk				
Cardiovascular disease	☐Yes	☐No	☐Unk				
Chronic Renal disease	☐Yes	☐No	☐Unk	Psychological/psychiatric condition If yes, specify: _____	☐Yes	☐No	☐Unk
Chronic Liver disease	☐Yes	☐No	☐Unk				
Chronic Lung disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unk	Other chronic diseases If yes, specify: _____	☐Yes	☐No	☐Unk
Immunosuppressive condition	☐Yes	☐No	☐Unk	Other underlying condition or risk behavior, specify: _____	☐Yes	☐No	☐Unk
Autoimmune condition	☐Yes	☐No	☐Unk				

History of substance use			
Tobacco smoking	☐Current	☐Former	☐Never
Vaping/E-cig	☐Current	☐Former	☐Never
Alcohol use disorder	☐Current	☐Former	☐Never
Other substances Specify: _____	☐Current	☐Former	☐Never

Additional Comments or Notes