Indiana State Department of Health
State Form 49686 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ☒ ✓ Mark mistakes like this: ●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** -

Name of ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Diarrhea
- ○ Bloody Diarrhea
- ○ Dehydration
- ○ Muscle Pain
- ○ Abdominal Cramps
- ○ Nausea
- ○ Vomiting
- ○ Gas/Bloating
- ○ Headache
- ○ Cellulitis
- ○ Bullae
- ○ Other, specify:

/ / **Date of Onset**

Duration of Symptoms in Days

/ / **Date First Positive Specimen Collected**

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Section 2. Clinical Information (continued)

Source of Positive Specimen:
- ○ Stool
- ○ Blood
- ○ Other, specify:

Culture Results:
- ○ Vibrio cholerae 01
- ○ Vibrio cholerae 0139
- ○ Vibrio alginolyticus
- ○ Vibrio fluvialis
- ○ Vibrio furnissii
- ○ Vibrio parahemolyticus
- ○ Vibrio vulnificus
- ○ No Positive Culture
- ○ Other, specify:

Was Vibrio strain resistant to antibiotics?
○ Yes ○ No **If Yes, antibiotic**

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

Physician/Hospital Phone - -

Was the patient hospitalized?
○ Yes ○ No **If Yes, admission date:** / /

Discharge date: / /

Hospital:

Was the patient treated with antibiotics after onset?
○ Yes ○ No

If Yes, antibiotic

Date started / / **Date ended** / /

Did the patient have any pre-existing conditions?

Alcoholism	○ Yes	○ No	○ Unknown	
Diabetes	○ Yes	○ No	○ Unknown	
Gastric Disease/Ulcer	○ Yes	○ No	○ Unknown	
Heart Disease	○ Yes	○ No	○ Unknown	Specify:
Hematologic Disease	○ Yes	○ No	○ Unknown	Specify:
Immunodeficiency	○ Yes	○ No	○ Unknown	
Liver Disease	○ Yes	○ No	○ Unknown	
Renal Disease	○ Yes	○ No	○ Unknown	

Other:

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Section 2. Clinical Information (continued)

Was patient receiving any of the following 30 days prior to illness onset?

Antibiotics	○ Yes	○ No	○ Unknown	Specify:
Chemotherapy	○ Yes	○ No	○ Unknown	
Radiotherapy	○ Yes	○ No	○ Unknown	
Systemic Steroids	○ Yes	○ No	○ Unknown	Specify:
Immunosuppressants	○ Yes	○ No	○ Unknown	Specify:
Ulcer Medication	○ Yes	○ No	○ Unknown	Specify:

Other:

Did the patient die? ○ Yes ○ No

Section 3. Risk Factors

During the 7 days prior to illness onset, did the patient:

Travel outside of Indiana?

○ Yes ○ No ○ Unknown

If Yes, where

/ / **Date of departure** / / **Date of return**

Have contact with untreated water? ○ Yes ○ No ○ Unknown

If Yes, where

/ / **Date**

Type of water: ○ Fresh ○ Salt ○ Brackish ○ Other

Do any of the following:

Swimming/Diving/Wading	○ Yes	○ No	○ Unknown
Walking on beach or shore	○ Yes	○ No	○ Unknown
Fall on rocks or shells	○ Yes	○ No	○ Unknown
Boating/Skiing/Surfing	○ Yes	○ No	○ Unknown
Construction/Repairs	○ Yes	○ No	○ Unknown
Bitten/Stung	○ Yes	○ No	○ Unknown

Sustain any wound during exposure? ○ Yes ○ No ○ Unknown

○ New wound ○ Pre-existing **Site on body:**

Eat raw or undercooked fish?

○ Yes ○ No

If Yes, type

Where eaten

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Section 3. Risk Factors (continued)

Eat shellfish (e.g., shrimp, scallops, crab, lobster, clams, mussels)?

○ Yes ○ No ○ Unknown

If Yes, type

Where eaten

Date eaten / /

Any raw? ○ Yes ○ No

If Yes, specify

Eat raw vegetables or fruits?

○ Yes ○ No ○ Unknown

If Yes, type

Where eaten

Does the patient know anyone else who has recently had an illness characterized by fatigue, diarrhea, fever, or abdominal pain?

○ Yes ○ No ○ Unknown

If Yes, name

Relationship

Phone number - -

Onset date / /

Was this person exposed to any of the same risk factors listed above?

○ Yes ○ No ○ Unknown

If Yes, describe

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number - -

Date / /