LISTERIOSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 49692 (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
- ○ Muscle Aches
- ○ Abdominal Cramps
- ○ Nausea
- ○ Vomiting
- ○ Headache
- ○ Other, specify:

/ /
Date of Onset

Duration of Symptoms in Days

/ /
Date First Positive Specimen Collected

Source of Positive Specimen:
- ○ CSF
- ○ Blood
- ○ Amniotic Fluid
- ○ Placenta
- ○ No Positive Culture
- ○ Other, specify:

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Section 2. Clinical Information (continued)

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:

Is patient immunocompromised?

○ Yes ○ No ○ Unknown **If Yes, why?**

Did patient die? ○ Yes ○ No

If patient is pregnant:

1. How many weeks gestation at time of illness onset? weeks
2. How many previous pregnancies has the patient had?
3. Was this pregnancy: ○ Single? ○ Multiple (twins, etc.)?
4. Did the infant have a positive specimen? ○ Yes ○ No

   Source: ○ Blood ○ CSF ○ Other, specify:
5. What was the outcome of the infant?

   ○ Alive and well ○ Alive, sick but survived ○ Born alive, but died ○ Abortion/Stillbirth

Section 3. Epidemiologic Information

List all the stores where the patient bought groceries that were consumed during the 3 weeks prior to illness onset.

Store Name:	Street Address:	Date:
		/ /
		/ /
		/ /
		/ /

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Section 3. Epidemiologic Information (continued)

Indicate whether the patient consumed the following foods or beverages during the 3 weeks prior to illness onset.

Food Item:	Date Consumed:	Brand Name:	Name of Place Purchased:
○ Rare or raw meat	/ /		
○ Chicken	/ /		
○ Packaged cold cuts	/ /		
○ Wieners (hot dogs)	/ /		
○ Dry sausage (summer sausage)	/ /		
○ Food from deli counter	/ /		
○ Smoked fish	/ /		
○ Unpasteurized milk products	/ /		
○ Mexican-style cheese	/ /		
○ Feta cheese	/ /		
○ Brie cheese	/ /		
○ Camembert cheese	/ /		
○ Bleu cheese	/ /		
○ Potato salad	/ /		
○ Cole slaw	/ /		
○ Raw vegetables/sprouts	/ /		
○ Pate′or meat spreads	/ /		

Section 4. Risk Factors

During the 3 weeks prior to illness onset, did the patient:

Eat any of the foods listed above at gatherings or food establishments? ○ Yes ○ No ○ Unknown

If Yes, where

/ /
Date

Have contact with any aborted fetuses of animals? ○ Yes ○ No ○ Unknown

If Yes, type of animal

Where

/ /
Date

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Section 4. Risk Factors (continued)

Do any gardening or digging in soil? ○ Yes ○ No ○ Unknown

If Yes, where

Date / /

Live or work near a construction or excavation site? ○ Yes ○ No ○ Unknown

If Yes, where

Date / /

Travel outside of Indiana? ○ Yes ○ No ○ Unknown

If Yes, where

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

Have any household contacts of the patient had an illness characterized by fever, headache, or diarrhea?

○ Yes ○ No ○ Unknown

If Yes, name:

Phone number: - -

Onset date: / /

Relationship:

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number - -

Date / /