

SHIGELLOSIS CASE INVESTIGATION - Page 1 of 5

Indiana State Department of Health
State Form 49694 (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: <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Native Hawaiian or Other Pacific Islander	Ethnicity: <input type="radio"/> White <input type="radio"/> Other/Multiracial <input type="radio"/> Unknown Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Is Age in day/mo/yr? <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years
Occupation	Phone of Employer/School/Day Care	
Name of <input type="radio"/> Employer <input type="radio"/> School <input type="radio"/> Day Care		
Address of Employer/School/Day Care		
City	State	ZIP Code

Section 2. Clinical Information

Symptoms: <input type="radio"/> Fever _____ . _____ (degrees) <input type="radio"/> Diarrhea <input type="radio"/> Blood in Stool <input type="radio"/> Abdominal Cramps <input type="radio"/> Nausea <input type="radio"/> Vomiting <input type="radio"/> Gas <input type="radio"/> Other, specify: _____	Date of Onset ____ / ____ / ____ Duration of Symptoms in Days _____ Date First Positive Specimen Collected ____ / ____ / ____	Source of Positive Specimen: <input type="radio"/> Stool <input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> Other, specify: _____
If Known, Shigella Species: <input type="radio"/> sonnei <input type="radio"/> flexneri <input type="radio"/> boydii <input type="radio"/> dysenteriae <input type="radio"/> No Positive Culture		Group: _____

SHIGELLOSIS CASE INVESTIGATION - Page 2 of 5

Indiana State Department of Health
State Form 49694 (R2/1-05)

Section 2. Clinical Information (continued)

Was Shigella strain resistant to any antibiotics?

Yes No Unknown

If Yes, antibiotic

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

Physician/Hospital Phone

Was the patient hospitalized before or during infection?

Yes No

If Yes, admission date: ____/____/____

Discharge date: ____/____/____

Hospital: _____

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

If Yes, antibiotic

____/____/____ Date started
____/____/____ Date ended

Did patient die? Yes No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 5 days prior to illness onset.

1. _____
Establishment Name

Address

Foods Eaten (list) Date ____/____/____

2. _____
Establishment Name

Address

Foods Eaten (list) Date ____/____/____

SHIGELLOSIS CASE INVESTIGATION - Page 3 of 5

Indiana State Department of Health
State Form 49694 (R2/1-05)

Section 3. Epidemiologic Information (continued)

3. _____
Establishment Name

Address

Foods Eaten (list) _____ **Date** ____/____/____

List all group gatherings where food was served that the patient attended during the 5 days prior to illness onset.

1. _____
Type of Gathering

Responsible Person

____ - ____ - ____ ____ ____ / ____ / ____
Phone Number **No. of Persons** **Date**

2. _____
Type of Gathering

Responsible Person

____ - ____ - ____ ____ ____ / ____ / ____
Phone Number **No. of Persons** **Date**

Section 4. Risk Factors

Does the patient work in or attend a high-risk setting (e.g., food handling, child-care center, health care, institution)?

Yes No Unknown

If Yes, specify

Address

____ - ____ - ____
Phone number

Does anyone in the patient's household work in or attend a high-risk setting (e.g., food handling, child-care center, health care, institution)?

Yes No Unknown

If Yes, where

Address

____ - ____ - ____
Phone number

SHIGELLOSIS CASE INVESTIGATION - Page 4 of 5

Indiana State Department of Health
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Section 4. Risk Factors (continued)

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

Go swimming?

Yes No Unknown

If Yes, date: / /

Type of water (pool, lake, river, water park, etc.)

If pool, was it public or private?

Public Private Unknown

Name of water body

Location of water body

Travel outside of Indiana? Yes No Unknown

If Yes, where

/ / / /
Date of departure Date of return

Consume any raw fruits, raw vegetables, fresh herbs, or salads? Yes No Unknown

If Yes, type of food

Where purchased

/ /
Date

List number of sexual partners during the last 7 days:

Males: Females: None Unknown

Did the patient have contact with anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain or who has been diagnosed with Shigella?

Yes* No Unknown

If Yes, name

Relationship

- - / /
Phone number Date

Question continued on next page.

*If more than one, please provide the above information for each on a separate sheet.

