Indiana Department of Health

Monkeypox Investigation Form

** *This form does not replace an NBS investigation - DO NOT FAX THIS FORM* **

NBS Patient ID: ____________________ **Date of Interview:** ____________________

Patient Information:

Patient Name: ____________________ ____________________
FIRST *LAST*

Date of birth: ____________________ **Birth country:** ____________________

Current sex: ☐ Female ☐ Male ☐ Unknown

How does the patient describe their gender?:

☐ Cisgender/not transgender ☐ Genderqueer, neither exclusively male or female ☐ Transgender female

☐ Transgender male ☐ Transgender unspecified ☐ Unknown ☐ Refused to answer ☐ Did not ask

☐ Other: ____________________

Sex assigned at birth: ☐ Female ☐ Male ☐ Unknown

Sexual orientation: ☐ Bisexual ☐ Lesbian or gay ☐ Prefer not to answer ☐ Straight ☐ Other: ____________________

Is the patient deceased?: ☐ Yes ☐ No ☐ Unknown **Deceased date:** ____________________ ☐ Date unknown

If deceased, did the patient die from this illness?: ☐ Yes ☐ No ☐ Unknown

Marital status: ____________________

Address & Contact

Patient street address: ____________________

City: ____________________ **Zip:** ____________________ **State:** ____________________

County of residence: ____________________ **Tribal Area:** ____________________

Home phone: ____________________ **Cell phone:** ____________________

Email: ____________________

Race & Ethnicity

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ Refused to answer ☐ Unknown ☐ Other: ____________________

If American Indian or Alaska Native, specify tribal affiliation: ____________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Signs & Symptoms

Symptoms

Did the patient experience symptoms during the course of illness?: ☐ Yes ☐ No ☐ Unknown

If yes, symptom onset date: ____________________ ☐ Unknown onset date

Symptom resolution date: ____________________ ☐ Unknown resolution date

Symptom Details

Did the patient have a fever?: ☐ Yes ☐ No ☐ Unknown

Did the patient have a rash?: ☐ Yes ☐ No ☐ Unknown

If yes, date of rash onset: ________________ ☐ Unknown onset date

If yes, where on the body is/was the rash?:

☐ Arms ☐ Legs ☐ Palms of hands
☐ Face ☐ Lips or oral mucosa ☐ Perianal
☐ Genitals ☐ Mouth ☐ Soles of feet
☐ Head ☐ Neck ☐ Trunk
☐ Unknown location ☐ Other: ____________________

Did the patient experience the following symptoms during the course of the illness?:

Enlarged lymph nodes	☐ Yes ☐ No ☐ Unk	Myalgia (muscle aches)	☐ Yes ☐ No ☐ Unk
Cough	☐ Yes ☐ No ☐ Unk	Headache	☐ Yes ☐ No ☐ Unk
Eye lesions	☐ Yes ☐ No ☐ Unk	Tenesmus/urgency to defecate	☐ Yes ☐ No ☐ Unk
Conjunctivitis (pink eye)	☐ Yes ☐ No ☐ Unk	Rectal pain	☐ Yes ☐ No ☐ Unk
Abdominal pain	☐ Yes ☐ No ☐ Unk	Rectal bleeding	☐ Yes ☐ No ☐ Unk
Pruritis (itching)	☐ Yes ☐ No ☐ Unk	Back pain	☐ Yes ☐ No ☐ Unk
Vomiting	☐ Yes ☐ No ☐ Unk	Pus or blood in stools	☐ Yes ☐ No ☐ Unk
Nausea	☐ Yes ☐ No ☐ Unk	Chills	☐ Yes ☐ No ☐ Unk
Runny nose	☐ Yes ☐ No ☐ Unk	Proctitis (rectal inflammation)	☐ Yes ☐ No ☐ Unk
Malaise (general feeling of illness or weakness)	☐ Yes ☐ No ☐ Unk	**Other**:	

Is there any evidence of ocular involvement?: ☐ Yes ☐ No ☐ Unknown
(ocular lesions, keratitis, eyelid lesions, conjunctivitis)

Has this individual been diagnosed with any other non-HIV acute infections during this current illness? ☐ Yes ☐ No ☐ Unknown

If yes, check all that apply:

☐ Chlamydia
☐ Gonorrhea
☐ Herpes Simplex Virus (HSV)
☐ Impetigo
☐ Shingles
☐ Syphilis
☐ Varicella
☐ Other acute infection ____________________
☐ Other sexually transmitted infection (STI) ____________________
☐ Other skin infection ____________________

Hospitalization

Was the patient hospitalized?: ☐ Yes ☐ No ☐ Unknown

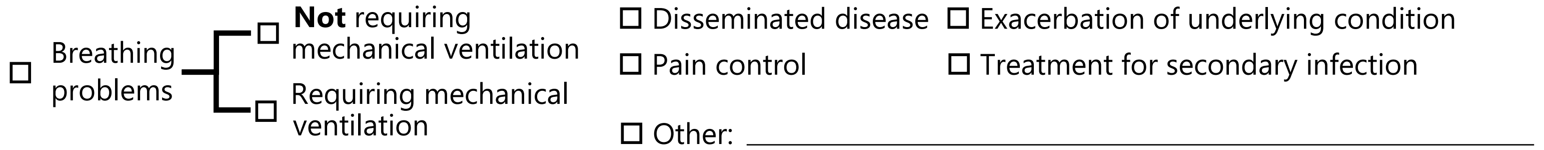
Most recent date of

admission: ____________________

discharge: ____________________

Name of hospital: ____

Reason for hospitalization (check all that apply):



☐ Breathing problems
- ☐ **Not** requiring mechanical ventilation
- ☐ Requiring mechanical ventilation

☐ Disseminated disease ☐ Exacerbation of underlying condition

☐ Pain control ☐ Treatment for secondary infection

☐ Other: ____

Did the patient visit any healthcare facility since symptom onset? ☐ Yes ☐ No ☐ Unknown

If yes, please provide details of visit, including location(s) and date(s): ____

____

Medical History

HIV STATUS

What is the patient's HIV status? ☐ HIV negative ☐ HIV positive ☐ Unknown **If positive, complete below:**

Clinical care coordinator name: ____

Clinical care coordinator phone number: ____________________________

Was viral load undetectable when it was last checked? ☐ Yes ☐ No ☐ Unknown

Is the patient currently receiving HIV pre-exposure prophylaxis (PrEP)? ☐ Yes ☐ No ☐ Unknown

IMMUNOCOMPROMISED STATUS

Is the patient immunocompromised due to a medical condition or treatment, excluding HIV?:

☐ Yes ☐ No ☐ Unknown

If yes, select below:

☐ Active cancer (specify): ____

☐ Asplenia ☐ Organ transplant ☐ Stem cell transplant ☐ Unknown

☐ Immunosuppressive medications/treatments: ____________________________

☐ Other: ____

Does the patient have any active exfoliative skin conditions?

☐ Yes ☐ No ☐ Unknown

If yes, select below:

☐ Acne ☐ Darier disease (keratosis follicularis) ☐ Psoriasis ☐ Severe diaper dermatitis with extensive areas of denuded skin

☐ Other: ____________________________

Vaccination History

Did the patient ever receive a vaccine against smallpox or monkeypox? ☐ Yes ☐ No ☐ Unknown

	REASON	VACCINE DATE	VACCINE TYPE	DOSE NUMBER
Vaccine 1	☐ Post-exposure ☐ Routine pre-exposure ☐ Pre-exposure ☐ Unknown		☐ ACAM2000 ☐ DryVax ☐ JYNNEOS	
Vaccine 2	☐ Post-exposure ☐ Routine pre-exposure ☐ Pre-exposure ☐ Unknown		☐ ACAM2000 ☐ DryVax ☐ JYNNEOS	
Vaccine 3	☐ Post-exposure ☐ Routine pre-exposure ☐ Pre-exposure ☐ Unknown		☐ ACAM2000 ☐ DryVax ☐ JYNNEOS	

Pregnant/Breastfeeding

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown **Due date:** ____________________

Is the patient currently breastfeeding? ☐ Yes ☐ No ☐ Unknown

Epidemiological Exposures

Did the patient have close contact with a known monkeypox case? ☐ Yes ☐ No ☐ Unknown

***If yes, complete contact section below**

Did the patient interact with anyone with symptoms of monkeypox? ☐ Yes ☐ No ☐ Unknown

Did the patient interact with anyone who later developed monkeypox symptoms? ☐ Yes ☐ No ☐ Unknown

Epi-Linked Contacts

Fill in contact type from options below:

	EPI-LINKED CASE ID	TYPE OF CONTACT	TYPE OF SHARED TRANSPORTATION
Contact 1			
Contact 2			
Contact 3			
Contact 4			
Contact 5			

Contact types

Face-to-face contact: within six feet without a mask (not including, intimate contact)	Shared bathroom (toilets, sinks, showers) Shared food, utensils, or dishes
Healthcare worker	Shared towels, bedding, or clothing
Identified air contact	Shared transportation (specify)
Indirect contact (e.g. shared sexual partners)	Unknown
Provide care to case—home setting	Other (specify)
Sexual or intimate contact	

Exposure Details

Is the patient a healthcare worker? ☐ Yes ☐ No ☐ Unknown

If yes, was the patient exposed at work? ☐ Yes ☐ No ☐ Unknown

Suspect location where the patient was exposed: ☐ Air travel ☐ Domestic ☐ International ☐ Unknown

☐ Other: ______________________________

Additional details on the suspected location of exposure (e.g. healthcare setting, large gathering etc.)

____

____

Number of identified contacts the patient exposed (named or anonymous): __________

Does the patient have pets in the household? ☐ Yes ☐ No ☐ Unknown

Travel History

Did the patient travel during the 3 weeks before symptom onset? ☐ Yes ☐ No ☐ Unknown

Did the patient travel after symptom onset? ☐ Yes ☐ No ☐ Unknown

	TRIP 1	TRIP 2	TRIP 3
Domestic or international?			
If domestic, state			
If international, country			
City			
Date of arrival to location			
Date of departure from location			
Reason for travel *(below)*			
Mode of travel *(below)*			
Flight #			
Seat #			

Reason for Travel

Airline or ship crew	Peace Corps	Visiting friends or relatives
Business	Refugee/Immigrant	Other
Military	Teacher/student	
Missionary	Tourism	

Mode of Travel

Aircraft	Passenger vessel
Automobile	Railway train
Motor bus	

Travel details: ______________________________

____

Did the patient have intimate or sexual contact with new partners on trip?: ☐ Yes ☐ No ☐ Unknown

Sexual Contact

Did the patient engage in sex and/or close intimate contact in the three weeks prior to symptom onset? ☐ Yes ☐ No ☐ Unknown

If yes, please complete the following section:

Gender of partner	Did patient report contact?	# of partners	If UNABLE to specify a number, select from the ranges
Male	☐ Yes ☐ No ☐ Unknown		☐ 1 ☐ 2 - 4 ☐ 5 - 9 ☐ 10 or more
Female	☐ Yes ☐ No ☐ Unknown		☐ 1 ☐ 2 - 4 ☐ 5 - 9 ☐ 10 or more
Transgender female	☐ Yes ☐ No ☐ Unknown		☐ 1 ☐ 2 - 4 ☐ 5 - 9 ☐ 10 or more
Transgender male	☐ Yes ☐ No ☐ Unknown		☐ 1 ☐ 2 - 4 ☐ 5 - 9 ☐ 10 or more
Other gender identity	☐ Yes ☐ No ☐ Unknown		☐ 1 ☐ 2 - 4 ☐ 5 - 9 ☐ 10 or more

Laboratory

Was lab testing performed?: ☐ Yes ☐ No ☐ Unknown

Collection date	Specimen source	Result
	lesion, lesion crust, lesion swab, serum, unknown, other (specify)	positive, negative, pending, indeterminate, not done, unknown, other (specify)