Ohio Department of Health

Mosquito-borne Illness Case Investigation Form

Reportable Condition:

- ☐ Dengue
- ☐ Chikungunya virus
- ☐ Zika virus
- ☐ LaCrosse encephalitis virus
- ☐ St. Louis encephalitis virus
- ☐ West Nile virus
- ☐ Other: _____

Case Classification: ☐ Confirmed ☐ Probable ☐ Suspected ☐ Not a Case **ODRS #:** _____

Patient

_____ Last Name _____ First Name _____ MI ( ) _____ Phone Number

_____ Street Address _____ City _____ County _____ Zip Code

Age: _____ Date of birth: / / Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Hawaiian Native/Pacific Islander ☐ Other: _____

Hispanic: ☐ Yes ☐ No ☐ Unknown

Pregnant (females): ☐ No ☐ Yes _____ Weeks Gestation Last Menstrual Period: / /

Course

Illness Onset Date: / / ☐ Asymptomatic

Hospitalized: ☐ Yes ☐ No Hospital: _____

Admission Date: / / Discharge Date: / / Diagnosis: _____

Died? ☐ Yes ☐ No Death Date: / /

Recovered? ☐ Yes ☐ No

Sequelae? ☐ Yes ☐ No Details: _____

Attending Physician: _____ Name ( ) _____ Phone Number

Address: _____

Conditions noted in chart: ☐ Meningitis ☐ Encephalitis ☐ Meningo-encephalitis ☐ Other: _____

Medical

Symptom	Yes	No	Unk	Symptom	Yes	No	Unk	Symptom	Yes	No	Unk
Fever	☐	☐	☐	Respiratory	☐	☐	☐	Cogwheel rigidity	☐	☐	☐
Max temp: _____ °F				Urinary	☐	☐	☐	Altered taste	☐	☐	☐
Chills	☐	☐	☐	Conjunctivitis	☐	☐	☐	Stiff neck	☐	☐	☐
Headache	☐	☐	☐	Rash	☐	☐	☐	Altered mental state	☐	☐	☐
Anorexia	☐	☐	☐	Describe: _____				Cranial nerve palsies	☐	☐	☐
Retro-orbital pain	☐	☐	☐	Joint/bone pain	☐	☐	☐	Drowsiness	☐	☐	☐
Severe malaise	☐	☐	☐	Myalgia	☐	☐	☐	Confusion	☐	☐	☐
Lymphadenopathy	☐	☐	☐	Muscle weakness	☐	☐	☐	Vertigo	☐	☐	☐
Nausea/vomiting	☐	☐	☐	Muscle twitch	☐	☐	☐	Seizures	☐	☐	☐
Diarrhea	☐	☐	☐	Ataxia	☐	☐	☐	Paralysis	☐	☐	☐
Abdominal pain	☐	☐	☐	Tremor	☐	☐	☐	Flaccid paralysis*	☐	☐	☐
Cough	☐	☐	☐	Abnormal reflexes	☐	☐	☐	Coma	☐	☐	☐
Shortness of breath	☐	☐	☐	Postural instability	☐	☐	☐	Other: _____	☐	☐	☐

* Acute flaccid paralysis (AFP) is characterized by a loss of skeletal muscle function resulting in a flaccid tone to the affected area. AFP may result from anterior ("polio") myelitis, peripheral neuritis, or post-infectious peripheral demyelinating neuropathy (i.e., Guillain-Barré syndrome).

Mosquito Exposure

Occupation: _____
(Provide exact job, type of business/industry, work shift, % of time spent outdoors while at work)

Average time spent outside per day (in the 30 days before illness onset):
☐ < 2 hours ☐ 2-4 hours ☐ 5-8 hours ☐ > 8 hours

Percent of time mosquito repellent worn when outdoors: ☐ Always ☐ 75% ☐ 50% ☐ 25% ☐ Never

History of mosquito bites (in 15 days before onset)? ☐ Yes ☐ No ☐ Unknown

If Yes, Describe: _____

Travel History

History of travel outside of home county in the 15 days before onset? ☐ Yes ☐ No

If Yes, Travel from date: __/__/____ Travel to date: __/__/____

Traveled to: _____

Purpose of travel: ☐ Tourism ☐ Business ☐ Military ☐ Peace Corp/federal deployment ☐ Missionary
☐ Airline/ship crew ☐ Visiting friends/relatives ☐ Refugee ☐ Immigrant
☐ Student/teacher ☐ Other: _____ ☐ Unknown

Sexual Contact

Sexual contact with anyone who traveled to/resided in an area with active/endemic transmission? ☐ Yes ☐ No

If Yes, Partner's travel from date: __/__/____ Partner's travel to date: __/__/____

If Yes, Partner's travel location(s): _____

If Yes, Was the sexual partner symptomatic during or within 2 weeks after travel? ☐ Yes ☐ No

If Yes, Was the sexual partner tested for arboviral diseases? ☐ Yes ☐ No

Date of last sexual contact (if known): __/__/____

Name of sexual partner: _____

Other Factors

Donated or received any blood, organ, or tissue products in 30 days before onset? ☐ Yes ☐ No

If Yes, Date: __/__/____ Blood Collecting Agency: _____

If patient is female, was she breastfeeding within 2 weeks of onset? ☐ Yes ☐ No

If patient is an infant, were birth defects reported or observed? ☐ Yes ☐ No ☐ Unknown

If Yes, Describe: _____

Vaccine

Did patient ever receive vaccine for:

Yellow fever	☐ Yes ☐ No	If Yes, Date:	__/__/____
Japanese encephalitis	☐ Yes ☐ No	If Yes, Date:	__/__/____
Tick-borne encephalitis	☐ Yes ☐ No	If Yes, Date:	__/__/____

TX Mode

Case acquired: ☐ Naturally ☐ Sexually ☐ Transfusion ☐ Transplantation ☐ Transplacentally
☐ Breastfeeding ☐ Occupationally ☐ Unknown

Case thought to be imported: ☐ Yes ☐ No ☐ Unknown

If Yes, From where? _____

Labs

Serology Tests (arboviruses, other etiologies):

Specimen Date	Tested For	Type of Test	Results	Lab Name
/ /				
/ /				
/ /				
/ /				

Cultures:

Specimen Date	Specimen Type	Results	Lab Name
/ /			
/ /			

Other Labs:

Test	Specimen Date	Results	Lab Name
WBC	/ /		
Diff	/ /		
Platelets	/ /		
CSF: WBCs	/ /		
CSF: Glucose	/ /		
CSF: Protein	/ /		
RT-PCR	/ /		

Reporting

Information Sources: ☐ Patient ☐ Provider ☐ Family/Friend ☐ Medical Record

Other Comments:

Investigated by: _____ Phone Number: ( ) _____

Agency: _____ Date: / /