TEXAS Department of State Health Services

Brucellosis Case Investigation

PATIENT

Last Name ______ **First Name** ______ **MI** ______ **Patient's Phone Number** (____)______

Street Address ______ **City** ______ **County** ______ **Zip** ______

Age: _________ **Date of Birth:** ____________________ **Sex: M F**

Race: White Black Asian Native American Other ____________________ **Hispanic: Yes No Unknown**

COURSE

Date of Onset: ______________ Was patient hospitalized? YES NO If YES, which hospital?______________

Date of admission: ______________ Date of discharge: ______________ **Discharge diagnosis**: ______________

Recovered? YES NO Died? YES NO Date of death: __________ Sequelae? YES NO If Yes, explain in comment section

Attending Physician: ______________ (Name) ( ) ______________ (Phone 1) ( ) ______________ (Phone 2)

Address: ______________________________ ______________________________

MEDICAL

Circle Response (Yes, No, Unknown):

Fever Y N Unknown

Max temp:____ ° F

Symptom			
Chills	Y	N	Unknown
Headache	Y	N	Unknown
Anorexia	Y	N	Unknown
Severe malaise	Y	N	Unknown
Sweating	Y	N	Unknown
Myalgia	Y	N	Unknown
Weakness	Y	N	Unknown
Nausea/vomiting	Y	N	Unknown
Diarrhea	Y	N	Unknown
Abscess	Y	N	Unknown
Splenomegaly	Y	N	Unknown
Hepatomoegaly	Y	N	Unknown
Anemia	Y	N	Unknown
Leukopenia	Y	N	Unknown
Lymphadenopathy	Y	N	Unknown
Abdominal pain	Y	N	Unknown

Other (List)

OTHER EPIDEMIOLOGY

Does the patient work in a livestock industry? (i.e. Production, Meat-packing, etc?) Y N Unknown

If yes, give occupation: ______________________________

(Give exact job, type of business or industry, location)

Has the patient had any animal contact within the 6 months prior to onset of illness? Y N Unknown

If yes, circle all species that apply. Cattle Swine Goats Sheep Dogs Cats Other ______________

Has the patient had contact with an aborting animal? Y N U If yes, specify: ______________

Has the patient had contact with a known brucellosis infected herd of cattle or swine? Y N Unknown
If yes, describe: ______________________________

Has the patient consumed unpasteurized milk? Y N Unknown

If yes, describe:______________________________

Has the patient consumed any unpasteurized goat milk cheese or cheese produced in Mexico? Y N Unknown

If yes, :______________________________

Where and from whom purchased

Patient's Name____

SEROLOGIC

Tests for	Date of specimen ----------->			Laboratory Name
	Type of test	Results	Results	

CULTURE

Specimen date	Specimen type	Species Isolated	Laboratory Name

OTHER LAB

Test	Specimen date	Results	Specimen Date	Results
WBC				
Diff				
Platelets				
AST				
ALT				
Other (Specify)				

THERAPY

Dose, duration and route of administration of:

Tetracycline ____

Streptomycin ____

Sulfonamides ____

Other ____

COMMENTS

Does the patient have a history of travel outside of home county within 15 days of onset? Y N U
If yes, document travel history:

If patient is female, is she pregnant? Y N U

If yes, week of pregnancy at onset of symptoms:______________________________

Outcome of pregnancy (Circle): Live birth Date________________ Still birth Date________________

Spontaneous abortion Date________________ Induced abortion Date________________

Have any household members experienced similar symptoms recently? YES NO (If yes, provide details)

Investigated by: ________________________________ Phone: ( ) ________________________

Agency: ________________________________ Date: ________________________