TEXAS Department of State Health Services

Tularemia 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: _____ City_____ State _____ Zip_____
Document additional hospitalizations and physician data in Comment Section.

CLINICAL

Circle Response (Yes, No, Unknown):

Fever Y N U
Max temp:_____ ° F Pulse at time of max temp: _____

Chills Y N U

Headache Y N U

Skin Lesion: Y N U **NOTE: Attach photo of lesion to report.**

If Y, Location(s):_____

Circle all that apply to Skin Lesions

Itchy Swollen Tender Oozing

Satellite Blisters Eschar Surrounding edema

Anorexia	Y	N	U
Severe malaise	Y	N	U
Weight Loss	Y	N	U
Nausea/vomiting	Y	N	U
Diarrhea	Y	N	U
Abdominal pain	Y	N	U
Conjunctivitis	Y	N	U
Sepsis	Y	N	U
Lymphadenopathy	Y	N	U

Cough Y N U

If Yes, was Cough (Circle)

Productive Bloody Purulent

Shortness of breath	Y	N	U
Pneumonia	Y	N	U
Chest Pain	Y	N	U
Meningitis	Y	N	U

Other:

OTHER EPIDEMIOLOGY

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

Recent military service: YES NO If YES, date of discharge:_____

Does the patient have a history of travel outside of home county within 15 days of onset? YES NO
If yes, document travel history.

Does the patient work outdoors or around wildlife, exotic pets or livestock? Y N U (If Yes, document in Comments Section on reverse)

In the 3 weeks prior to illness, did the patient have any contact with wildlife (hunting, camping, etc)? Y N U (If Yes, document in Comments Section)

Has the patient been bitten by ticks or deer flies in the three weeks prior to illness? Y N U (If Yes, document in Comments Section)

Are there exotic rodents or other pets in the patient's household? Y N U If Yes, have any of these pets been ill recently? Y N U
(If Yes, document in Comments Section)

Have any household members experienced similar symptoms recently? Y N U (If Yes, provide details)

Patient's Name: _____

SEROLOGIC	Tests for	Date of specimen ===>			Laboratory Name
		Type of test	Results	Results	

CULTURE	Specimen date	Specimen type	Results	Laboratory Name

OTHER LAB	Test	Specimen date	Results	Specimen Date	Results
	WBC				
	Diff				
	Platelets				
	SGOT				
	SGPT				
	Other (Specify)				

XRAY	Type	Date	Results

OTHER COMMENTS	

Investigated by: _____ Phone: (____) _____

Agency: _____ Date: _____