



# Plague Case Investigation Report



Form Approved  
OMB No. 0920-0009

Date of report:

Case ID #:

## Reporting and Basic Contact Information

Person reporting the case:		Person taking the report:	
Agency/affiliation:		Agency/affiliation:	
Phone number/Email:		Phone number/Email:	
Has the local health department been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide name, phone number and/or email of contact person:	
Treating Physician(s)		Phone number and/or email of contact person:	
Hospital:	City/State:	Phone:	

## Patient Demographics

Age:	Sex: Female Male Unknown	Patient Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown	Patient race: (select all that apply) American Indian/Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White Unknown
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Residence: State: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Works primarily: Indoors   Outdoors   Both   Unknown

## Medical History and Current Illness

Any underlying medical conditions? Yes No Unknown	If yes, please indicate all conditions that apply:		
	Cancer Cardiovascular Disease For females - pregnant Other (specify):	Diabetes Mellitus Immunocompromised	Pulmonary Disease Renal Disease

Date of initial symptom onset: _____ / _____ / _____ mm   dd   yyyy	Location where first seen: Emergency Department   Urgent Care Center Hospital   Unknown Outpatient clinic/office   Other: _____
Date first seen by medical person: _____ / _____ / _____ mm   dd   yyyy	

<b>Symptoms at initial presentation:</b>	<u>Yes</u> <u>No</u> <u>Unknown</u>	<u>Yes</u> <u>No</u> <u>Unknown</u>
Fever		Swollen tender glands
Sweats/chills/rigors		Sore throat
Weakness/lethargy/malaise		Headache
Shortness of breath		Confusion/delirium
Chest pain		Muscle/joint pains
Cough (onset date _____)		Nausea, vomiting, and/or diarrhea
Bloody sputum		Abdominal pain
Other(s): _____		

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

### Medical History and Current Illness (continued)

If known, vital signs at initial presentation: (if unknown, check here ) Date: \_\_\_/\_\_\_/\_\_\_

Temperature: \_\_\_\_\_ Blood pressure: \_\_\_/\_\_\_ Heart rate: \_\_\_\_\_ Respiratory rate: \_\_\_\_\_  
mm dd yyyy

<b>Bubo:</b>	<b>Location (please circle right or left):</b>	<b>Description (size, tenderness, erythema, etc.):</b>
Yes	Axillary (Right or Left)      Inguinal (Right or Left)	
No	Cervical (Right or Left)      Other: _____	
Unknown	Femoral (Right or Left)      _____	

**Insect bites or Skin ulcer:**      **Description of bite and/or ulcer (including location and date of onset):**

(please circle bite, ulcer, or both)

Yes      No      Unknown      \_\_\_\_\_

### Radiographic and Laboratory Findings

**Chest X-ray:**

Yes (date: \_\_\_/\_\_\_/\_\_\_)

No      mm dd yyyy

Unknown

**Results:**

Clear/normal

Hilar adenopathy

Infiltrates, unilateral

Infiltrates, bilateral

Interstitial changes

Pleural effusion

Pulmonary abscess

Pulmonary nodules

Unknown

**Initial blood tests:** (date: \_\_\_/\_\_\_/\_\_\_)

WBC (x 10<sup>3</sup>): \_\_\_\_\_ Differential (indicate %)      Segs: \_\_\_\_\_      Bands: \_\_\_\_\_      Lymphs: \_\_\_\_\_  
mm dd yyyy

Hgb (mg/dl) or Hct: \_\_\_\_\_ Platelets (x 10<sup>3</sup>): \_\_\_\_\_ BUN (U/dl): \_\_\_\_\_ Creatinine (mg/dl): \_\_\_\_\_

**Bacteria seen on blood smear?**     Yes     No     Unknown    (date of blood smear: \_\_\_/\_\_\_/\_\_\_)

**Plague testing:**

Yes    No    Unk

Date specimen collected  
(mm / dd / yyyy)

Test(s) performed - Results

(e.g. culture - positive, DFA - positive, PCR - negative)

Blood culture (1)      \_\_\_/\_\_\_/\_\_\_

Blood culture (2)      \_\_\_/\_\_\_/\_\_\_

Bubo aspirate      \_\_\_/\_\_\_/\_\_\_

Sputum sample      \_\_\_/\_\_\_/\_\_\_

CSF sample      \_\_\_/\_\_\_/\_\_\_

Serology: **S1:** Date drawn \_\_\_/\_\_\_/\_\_\_ Titer: \_\_\_\_\_ **S2:** Date drawn \_\_\_/\_\_\_/\_\_\_ Titer: \_\_\_\_\_  
mm dd yyyy

### Clinical Course and Treatment

**Was the patient hospitalized?**     Yes     No     Unknown    Admit date: \_\_\_/\_\_\_/\_\_\_    Discharge date: \_\_\_/\_\_\_/\_\_\_  
mm / (dd)      mm / dd

**Was the patient isolated?**       No     Respiratory     Contact     Unknown      Date isolated: \_\_\_/\_\_\_/\_\_\_  
mm / dd

**If hospitalized, what was the maximum temperature noted within first 72 hours of hospitalization:** \_\_\_\_\_

**How many days elapsed from symptom onset until symptoms improved (i.e. afebrile for 24 hours):** \_\_\_\_\_

**Did the patient receive antibiotics?**

Yes     No     Unknown

If yes, please list all antibiotics:

Date started

Date stopped

Dosage and schedule

1. \_\_\_\_\_      \_\_\_/\_\_\_/\_\_\_      \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_

2. \_\_\_\_\_      \_\_\_/\_\_\_/\_\_\_      \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_

3. \_\_\_\_\_      \_\_\_/\_\_\_/\_\_\_      \_\_\_/\_\_\_/\_\_\_      \_\_\_\_\_  
mm / dd      mm / dd

### Clinical Course and Treatment (continued)

Complications :	<u>Yes</u>	<u>No</u>	<u>Unknown</u>	<u>Yes</u>	<u>No</u>	<u>Unknown</u>
Amputation/limb ischemia						Multisystem (i.e. $\geq 2$ ) organ failure
Bleeding/DIC						Renal failure (Cr $>2.0$ mg/dl)
Cardiac arrest						Secondary pneumonia
Intubation						Shock (SBP $<90$ mmHg)
Other(s): _____						

**Initial diagnosis given:** \_\_\_\_\_

**Number of days from initial diagnosis until plague diagnosis given:** \_\_\_\_\_

**Classification of clinical syndrome: (please check here if unknown )**

Bubonic   
  Pneumonic   
  Septicemic   
  Pharyngeal   
  Meningitic   
  Ocular   
  Gastrointestinal

Primary (select one)

Secondary (select all that apply)

**Outcome:**

Recovered, no complications

Recovered, complications (please specify): \_\_\_\_\_

Recovered, unknown complications

Died (please specify cause and date of death): \_\_\_\_\_

Unknown

### Epidemiologic and Environmental Investigation

**Possible exposure source and location: (please check all that apply)**

Yes (specify location below)   
  No   
  Unknown

Contact with sick or dead animals

Exposure to abandoned burrows

Hunting, including contact with wild animals

Flea or insect bites

Contact with someone ill or who has died in last week

Contact with known plague patient

Other (specify): \_\_\_\_\_

**Pets:** Are there pets in the home?    No    Dogs (# \_\_\_\_\_)    Cats (# \_\_\_\_\_)    Other (specify below)

If have pets, are any ill or have any died?    No    Yes    Unknown

If have pets, have they brought home dead animals?    No    Yes    Unknown

**Is this patient's illness associated with any other human plague cases?**    No    Yes (specify below)    Unknown

**Did this patient's illness result in any secondary human plague cases?**    No    Yes (specify below)    Unknown

**Comments regarding the environmental and epidemiologic investigation (including exposures during 10 days preceding illness onset; any travel within or outside of the United States; contact tracing of household, school/work, and community close contacts for pneumonic cases; and/or explanations from above):**

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