

WORKSHEET: EVALUATING PATIENTS FOR SMALLPOX

Identification Number	
Person Completing Form	
Date of Contact with Case	
Today's Date (mo/da/yr)	

PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE INITIAL

Date of Birth: ____/____/____ **Age:** ____ **Sex:** Male Female

Telephone:
 Home _____ Other _____

Address: _____
CITY STATE ZIP

Race: White Black Asian Other **Ethnicity:** Hispanic Non-Hispanic **Country of Birth:** _____

Where is the patient now? Home Doctor's Office
 Emergency Room *(if checked, continue below)*
 Hospital *(if checked, continue below)*
 Other *(specify)* _____

Hospital Name _____
 City/State _____
 Admission Date ____/____/____ Discharge Date ____/____/____
 Hospital Telephone Number (____) _____

PROVIDER INFORMATION

Name: _____

Patient Population: Adult Peds Both

Specialty: _____

Telephone:
 Type _____ (____) _____
 Type _____ (____) _____

E-mail Address: _____

Name: _____

Patient Population: Adult Peds Both

Specialty: _____

Telephone:
 Type _____ (____) _____
 Type _____ (____) _____

E-mail Address: _____

CLINICAL INFORMATION

PRODROME / SYMPTOMS 1-4 DAYS BEFORE RASH ONSET

Did the patient have a fever and other illness 1-4 days before rash onset? Yes No Unknown

Date of prodrome onset ____/____/200__

Date of first fever ≥101° F: ____/____/____

What was the highest temperature? _____° F or _____° C

On what date? ____/____/____

Check all features of the prodrome that apply:

<input type="checkbox"/> No/Mild prodrome (<1 day)	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Headache	<input type="checkbox"/> Sore throat*
<input type="checkbox"/> Backache	<input type="checkbox"/> Other <i>(specify)</i> _____
<input type="checkbox"/> Chills	
<input type="checkbox"/> Vomiting	

*In infants, this may manifest as drooling or refusing to eat or drink.

Was the patient toxic or seriously ill? Yes No Unknown

Was the patient able to do most normal activities? Yes No Unknown

RASH

Date of rash onset ____/____/200__

Was the rash acute (sudden) in onset? Yes No Unknown

Was a black scar (eschar) present before or at the time of appearance of the rash? Yes No Unknown

Is the rash *generalized* (i.e., multiple parts of the body) or *focal* (i.e., only one part of the body)? Generalized Focal

Where on the body were the first lesions noted?

<input type="checkbox"/> Face	<input type="checkbox"/> Arms
<input type="checkbox"/> Trunk	<input type="checkbox"/> Legs
<input type="checkbox"/> Inside the mouth	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other <i>(specify)</i> _____	

Since rash onset, where on the body was the rash most dense?

<input type="checkbox"/> Trunk	<input type="checkbox"/> Equally distributed everywhere
<input type="checkbox"/> Face or scalp	<input type="checkbox"/> Other <i>(describe)</i> _____
<input type="checkbox"/> Distal extremities (arms, legs)	

Are there any lesions on the palms or soles? Yes No Unknown

What kind of lesions does the patient have now? *(check all that apply)*

<input type="checkbox"/> Macules (flat spots)	<input type="checkbox"/> Pustules (blisters filled with pus)
<input type="checkbox"/> Papules (solid bumps)	<input type="checkbox"/> Crusts
<input type="checkbox"/> Vesicles (fluid-filled blisters)	<input type="checkbox"/> Other _____

If more than one kind of lesion, which kind of lesion is now the most common? _____

Are the lesions now:

<input type="checkbox"/> Superficial (on top of the skin)
<input type="checkbox"/> Deep (feel embedded deeply in the skin)
<input type="checkbox"/> Neither <i>(describe)</i> _____

How many lesions are present? (in total) _____

If no precise count is available, please estimate:

<input type="checkbox"/> <20
<input type="checkbox"/> 20-50 (able to count in less than a minute)
<input type="checkbox"/> 51-499 (typically an average case of varicella has 200-400 lesions)
<input type="checkbox"/> >500 (lesions confluent in some places, can't see normal skin between)

On any one part of the body (e.g., face or arm), are all the lesions in the same state of development? Yes No Unknown

How big are most of the lesions? *(Do not measure superinfected lesions.)*

<input type="checkbox"/> Small (1-5 mm)
<input type="checkbox"/> Large (5-10 mm)
<input type="checkbox"/> Neither <i>(describe)</i> _____

Have any lesions crusted? Yes No Unknown

If Yes, how many days did it take for the first lesions to crust? _____

How itchy is the rash? Not at all Somewhat Very Unknown

Does the patient have lymphadenopathy? Yes No Unknown

If Yes, describe: _____

Is the patient toxic or moribund now? Yes No Unknown

If Yes, describe: _____

Continues

CLINICAL NOTES

SOURCE / EXPOSURE INFORMATION

Is chickenpox (varicella) occurring in the community? Yes No Unknown

Has the patient had contact with a person with chickenpox or shingles 10-21 days before rash onset? Yes No Unknown

If Yes, give date(s) and type of contact: _____

In the 3 weeks before onset of illness: (applies to remainder of section)

Has the patient been in contact with a person with any other rash illness? Yes No Unknown

If Yes, please specify, with date: _____

Has the patient traveled? Yes No Unknown

If Yes, please provide locations and dates of travel:
Place: _____ Dates: _____

Place: _____ Dates: _____

Has the patient had contact with mice? Yes No Unknown

Has the patient been camping, hiking, or exposed to woods before onset of illness? Yes No Unknown
If Yes, please provide details and dates:
_____ Dates: _____
_____ Dates: _____

_____ Dates: _____
_____ Dates: _____

Has the patient received insect bites? Yes No Unknown

Has the patient been exposed to ticks? Yes No Unknown

VACCINATION HISTORY

Has the patient received chickenpox (varicella) vaccine? Yes No Unknown
(Chickenpox vaccine was licensed in the United States in 1995.)

If Yes, dose #1 date ____/____/____ or age _____
dose #2 date ____/____/____ or age _____
(only persons >13 years receive a second dose)

Has the patient ever received smallpox vaccine? Yes No Unknown
(The smallpox vaccine was routinely given in the U.S. until 1972, was recommended for health care providers until 1976, was administered in the military until 1990.)

If Yes, when was the most recent vaccination? ____/____/____
or at what age? _____

MEDICAL HISTORY

Has the patient ever had chickenpox or shingles? Yes No Unknown
If Yes, when? ____/____/____ or at what age? _____

Is the patient immunocompromised? Yes No Unknown
If Yes, specify type of illness (e.g., cancer, HIV/AIDS) _____

Does the patient have any other serious underlying medical illnesses? (e.g., asthma) Yes No Unknown
If Yes, please list: _____

Is the patient sexually active? Yes No Unknown

Is the patient pregnant? Yes No Unknown

DIFFERENTIAL DIAGNOSIS

MEDICATIONS

Is the patient on medications that suppress the immune system? (e.g., steroids, chemotherapy, radiation) Yes No Unknown

If Yes, name of medication: _____
Dosage: _____
Method of administration: _____

Is the patient taking antiviral medications? Yes No Unknown

If Yes, name of medication: _____
Dosage: _____
Method of administration: _____

Please list all prescription and non-prescription medications that the patient has taken in the past three weeks. (List drug, dosage, route, dates)

Is there a history of illicit drug use? Yes No Unknown

If Yes, please specify drug, amount (if known), route, and dates:

LABORATORY

Have you tested the patient for chickenpox? Yes No Unknown
If Yes, what type of test? _____

Results of tests: _____
Date: ____/____/____

Other lab testing — Please complete last page

Other comments: _____

PLEASE LIST ALL LABORATORY TESTS ORDERED OR PERFORMED REGARDING THIS ILLNESS

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: State _____
 Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: State _____
 Other _____

Date: _____ / _____ / _____ Results: _____
Disease: _____
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Date: _____ / _____ / _____ Results: _____
Disease: _____
Test: _____
Laboratory: State _____
 Other _____