TEXAS Department of State Health Services

Anthrax 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):

Eschar Yes No Unknown

If Y, Location:_____

NOTE: Attach photo of eschar to report.

Fever Y N UNKNOWN

Max temp:_____ ° F

Pulse at time of max temp: _____

Chills Y N UNKNOWN

Headache Y N UNKNOWN

Anorexia Y N UNKNOWN

Severe malaise Y N UNKNOWN

Lymphadenopathy Y N UNKNOWN

Cough Y N UNKNOWN

Nausea/vomiting Y N UNKNOWN

Diarrhea Y N UNKNOWN

Abdominal pain Y N UNKNOWN

Shortness of breath Y N UNKNOWN

Rash Y N UNKNOWN

(describe)_____)

Other (List)

OTHER EPIDEMIOLOGY

Does the patient reside within the Texas anthrax enzootic area? Y N UNKNOWN

Does the patient work with or around livestock? Y N UNKNOWN

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

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

Has the patient had any contact with animal skins, furs, or hair? YES NO (If YES, describe)

Have any household members experienced similar symptoms recently? YES NO (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				
	AST				
	ALT				
	Other (Specify)				

XRAY	Type	Date	Results

COMMENTS

Investigated by: _____ Phone: (_____) _____

Agency: _____ Date: _____