E. COLI CASE HISTORY REPORT

PLEASE REPORT ONLY PATHOGENIC STRAINS OF E. COLI

I. DEMOGRAPHIC INFORMATION

1. Name-Last First

Home Phone: ( ) ____ - ____

Work Phone: ( ) ____ - ____

Street Address:

5. County:

6. Sex: ☐ 1 Male ☐ 2 Female ☐ 9 Unknown

7. Date of Birth: ____/____/____ (mo/day/yr) or Age: ____ years or Age: ____ months

2. City:

3. State: ____

4. Zip Code: ____

8. Race (check one): ☐ 1 American Indian or Alaska Native ☐ 2 Asian or Pacific Islander ☐ 3 Black ☐ 5 White ☐ 6 Other ☐ 9 Unknown

9. Ethnicity (check one): ☐ 1 Hispanic ☐ 2 Non-Hispanic ☐ 9 Unknown

II. ISOLATE INFORMATION (Specify serotype)

10. Source of Specimen: ☐ 1 Stool (whole, stool swab, rectal swab) ☐ 2 Other (specify): ____

11. Date of Specimen Collection: ____/____/____ (mo/day/yr)

12. Was identification of the O157 serogroup confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control? ☐ 1 Yes ☐ 2 No ☐ 9 Unknown

13. Was identification of the H7 serotype confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control? ☐ 1 Yes ☐ 2 No ☐ 9 Unknown

14. This case reported by:

☐ 1 Hospital lab ☐ 4 Infection Control Practitioner
☐ 2 Other lab ☐ 5 School
☐ 3 Physician ☐ 6 Other (specify): ____

Reporting laboratorian's name: ____

Telephone: ( ) ____ - ____

Physician's name: ____

Telephone: ( ) ____ - ____

III. CLINICAL INFORMATION

15. Date of Illness Onset:

____/____/____ (mo/day/yr) ☐ Unknown

16. Did the patient have: (please check one answer for each question)

	Yes (1)	No (2)	Unknown (9)
Diarrhea	☐	☐	☐
Visible blood in stools	☐	☐	☐
Fever (or felt feverish)	☐	☐	☐
Abdominal cramps	☐	☐	☐

17. Was the patient admitted overnight to a hospital for this illness? ☐ 1 Yes ☐ 2 No ☐ 9 Unknown

If yes, name of hospital: ____

18. Did the patient: (please check one answer for each question)

	Yes (1)	No (2)	Unknown (9)
have Hemolytic Uremic Syndrome? (HUS is hemolytic anemia, low platelet count, kidney impairment):	☐	☐	☐
have Thrombotic Thrombocytopenic Purpura? (TTP is hemolytic anemia, low platelet count, kidney impairment, central nervous system involvement, fever):	☐	☐	☐
undergo dialysis?	☐	☐	☐
have surgery?	☐	☐	☐
die?	☐	☐	☐

IV. PUBLIC HEALTH INFORMATION

19. Does the patient attend or work in:

	Yes (1)	No (2)	Unknown (9)
A child day care center?	☐	☐	☐
An institution?	☐	☐	☐

If yes, where: ____

20. Is the patient usually employed as:

	Yes (1)	No (2)	Unknown (9)
a health care worker?	☐	☐	☐
a food handler?	☐	☐	☐

If yes, where: ____

V. DATA COLLECTOR INFORMATION

Person Completing This Form:	Agency:	Phone Number: ( ) ____ - ____	Date: ____/____/____ (mo/day/yr)

*Note: If patient was hospitalized, please attach copy of discharge summary if possible.

(10/93)

20. In the 7 days before the illness began, did the patient eat at:

	Yes 1	No 2	Unknown 9
a fast food restaurant?	☐	☐	☐
another restaurant?	☐	☐	☐

If yes, name and location of restaurant(s):

_____

_____

_____

_____

_____

21. In the 7 days before the illness began, did the patient eat or drink any of the following items at home, in a restaurant, or in any other place?

	Yes 1	No 2	Unknown 9
Raw (unpasteurized) milk	☐	☐	☐
Other dairy products made from raw (unpasteurized) milk	☐	☐	☐
Well water	☐	☐	☐
Other unchlorinated water	☐	☐	☐
Apple cider	☐	☐	☐
Any ground beef or hamburger	☐	☐	☐
Pink or red ground beef or hamburger	☐	☐	☐
Any steak or roast beef	☐	☐	☐
Pink or red steak or roast beef	☐	☐	☐

22. In the 7 days before the illness began, did the patient:

	Yes 1	No 2	Unknown 9
Visit or live on a farm?	☐	☐	☐
Have contact with any cows or cattle?	☐	☐	☐
Touch any cow manure?	☐	☐	☐
Have contact with any children who attend a day care center?	☐	☐	☐
Change any diapers?	☐	☐	☐
Have contact with any children who use diapers?	☐	☐	☐
Go swimming?	☐	☐	☐

If yes, where? _____

Travel to another state? ☐ Yes 1 ☐ No 2 ☐ Unknown 9

If yes, where? _____

Travel to another country? ☐ Yes 1 ☐ No 2 ☐ Unknown 9

If yes, where? _____

23. Did anyone else in the patient's home have diarrhea in the 7 days before or after this patient's illness began?

☐ Yes 1 ☐ No 2 ☐ Unknown 9

If yes, please obtain the following information on these people:

Name	Age	Sex	Bloody Stools? Yes 1	No 2	Unknown 9
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

24. Does the patient know anyone else who has had a similar illness in the past 3 weeks? ☐ Yes 1 ☐ No 2 ☐ Unknown 9

If yes, please obtain names of persons with similar illnesses: _____ _____

_____ _____ _____ _____

25. Did this case occur as part of an outbreak (two or more cases of *E. coli* O157:H7 infection associated by time and place?)

☐ Yes 1 ☐ No 2 ☐ Unknown 9

If yes, please describe: _____

_____

_____

VIII. ADDITIONAL EPIDEMIOLOGIC INFORMATION OR COMMENTS

_____

_____