TEXAS Department of State Health Services

Q Fever Case Investigation

PATIENT

_____ _____ _____ (_____)_____
Last Name **First Name** **MI** **Patient's Phone Number**

_____ _____ _____ _____
Street Address (Do not use PO Box) **City** **County** **Zipcode**

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: _____

Attending Physician: _____ (_____)_____ (_____)_____
(Name) (Phone) (Fax)

Address:_____ _____
(Street Address) (City, State, Zipcode)

MEDICAL

Circle Response (Yes, No, Unknown):

Fever >100.5°F	Yes	No	Unknown	Max temp: _____°F	Pneumonia	Yes	No	Unknown
Myalgia	Yes	No	Unknown		Nausea	Yes	No	Unknown
Retrobulbar headache	Yes	No	Unknown		Vomiting	Yes	No	Unknown
Malaise	Yes	No	Unknown		Diarrhea	Yes	No	Unknown
Fatigue	Yes	No	Unknown		Abdominal pain	Yes	No	Unknown
Confusion	Yes	No	Unknown		Hepatomegaly	Yes	No	Unknown
Chills/Rigors	Yes	No	Unknown		Hepatitis	Yes	No	Unknown
Night sweats	Yes	No	Unknown		Endocarditis	Yes	No	Unknown
Dyspnea	Yes	No	Unknown		Other (list):			
Nonproductive cough	Yes	No	Unknown					
Chest pain	Yes	No	Unknown					

OTHER EPIDEMIOLOGY

Patient's occupation: _____
(Give exact job, type of business or industry, location)

Has the patient had any animal contact within the 60 days prior to onset of illness? Yes No Unknown

If Yes, circle all species that apply. Cattle Swine Goats Sheep Dogs Cats Pigeons Rabbits Other _____

Has the patient had contact with birthing animals? Yes No Unknown **If Yes**, specify: _____

Has the patient had exposure to unpasteurized milk or cheese? Yes No Unknown **If Yes**, specify: _____

Does the patient have a history of travel outside of County of residence in the 30 day prior to onset? Yes No Unknown
If Yes, give travel history:

County	City/State/Country	How Long	From (date)	To (date)	Animal Contact? (Circle)
					Yes No Unknown
					Yes No Unknown
					Yes No Unknown

Have any household members experienced similar symptoms in the last year? Yes No Unknown **If Yes**, provide details:

Did the patient have pre-existing medical conditions? Yes No Unknown **If Yes, Circle all that apply**:

Immunocompromised Pregnancy Valvular Heart Disease Vascular Graft Chemotherapy in last year Diabetes Organ Transplant

Other _____

Patient's Name: _____

SEROLOGIC

Date Collected	Test	Results	Test	Results	Laboratory Name	Normal Value
	Phase I – IgG (Acute)		**Phase II IgG (Acute)**			
	Phase I – IgM (Acute		**Phase II IgM (Acute)**			
	Phase I – IgG (Conv)		**Phase II IgG (Conv)**			
	Phase I – IgM (Conv)		**Phase II IgM (Conv)**			

CULTURE

Specimen date	Specimen type	Species Isolated	Laboratory Name

OTHER LAB

Test	Specimen date	Results	Specimen date	Results	Normal values for Lab
WBC					
Differential					
Platelets					
AST/SGOT					
ALT/SGPT					
Other (Specify)					

THERAPY

Dosage, duration and route of administration of:

Tetracycline _____

Streptomycin _____

Sulfonamides _____

Other _____

FINAL DIAGNOSIS

This Section Completed by Central Office Zoonosis Control

Confirmed acute Q fever ☐ Probable acute Q fever ☐

Confirmed chronic Q fever ☐ Probable chronic Q fever ☐

Confirmed acute Q fever: A laboratory confirmed case that either meets clinical case criteria or is epidemiologically linked to a lab confirmed case.
Probable acute Q fever: A clinically compatible case of acute illness (meets clinical evidence criteria for acute Q fever illness) that has laboratory supportive results for past or present acute disease (antibody to Phase II antigen) but is not laboratory confirmed.
Confirmed chronic Q fever: A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that is laboratory confirmed for chronic infection.
Probable chronic Q fever: A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that has laboratory supportive results for past or present chronic infection (antibody to Phase I antigen).

Note: See CSTE Position Statement Number: 09-ID-54 for complete Q fever case definition.
Website address: http://wwwn.cdc.gov/NNDSS/script/casedef.aspx?CondYrID=814&DatePub=1/1/2009

State Health Department Official who reviewed this report:	
Name:	
Title:	**Date:**

Investigated by: _____ Phone: _(_____)_____

Agency: _____ Date: _____