

West Nile Virus Case History Form

Patient Information:

Last Name: _____ **First Name:** _____ **DOB:** ___/___/___ **Medical Rec #:** _____
Address: _____ **City:** _____ **Zip Code:** _____
Phone: Home (_____) _____ Work (_____) _____ **Occupation:** _____
Sex: Male Female Unknown **Ethnicity:** Hispanic Non-Hispanic Unknown **Race:** White Black Unknown Asian/ Pacific Islander American Indian/Alaskan Native Other: _____

Physician Information (Mandatory):

Name: _____ **Facility:** _____
Pager/Phone: (_____) _____ **Fax:** (_____) _____ **Email:** _____

Date of first symptom(s): ___/___/___ Hospitalized or ER / Outpatient
If hospitalized, admit date: ___/___/___ **Discharge date:** ___/___/___ **If patient died, date of death:** ___/___/___

Clinical syndrome:

Encephalitis Yes No Unk
 Aseptic meningitis Yes No Unk
 Acute flaccid paralysis Yes No Unk
 Febrile illness Yes No Unk
 Asymptomatic Yes No Unk
 Other _____

Do the following apply anytime during current illness:

In ICU Yes No Unk
 Fever ≥38° Yes No Unk
 Headache Yes No Unk
 Rash Yes No Unk
 Stiff neck Yes No Unk
 Muscle pain/weakness Yes No Unk
 Altered consciousness Yes No Unk
 Seizures Yes No Unk

| CSF Results | CBC Results |
|-------------------|-------------------|
| Date: ___/___/___ | Date: ___/___/___ |
| RBC: _____ | WBC: _____ |
| WBC: _____ | %Diff: _____ |
| %Diff: _____ | HCT: _____ |
| Protein: _____ | Plt: _____ |
| Glucose: _____ | |

Other lab results (MRI/CT, LFTs, etc.): _____

Past medical history:

Hypertension: Yes No Unk
 Diabetes Type _____ Yes No Unk
 Other: _____

Exposures/Travel within 4 wks of onset (specify details):

Mosquito bites/exposure: Yes No Unk
 Traveled outside of California: Yes No Unk
 Traveled outside the U.S.: Yes No Unk
 Ever traveled outside the U.S.: Yes No Unk

Other pertinent information (specify details):

Immunocompromised patient: Yes No Unk
 Yellow fever vaccination: Yes No Unk
 Date: ___/___/___
 Donated blood: Yes No Unk
 Date: ___/___/___
 Donated organ: Yes No Unk
 Date: ___/___/___
 Received blood: Yes No Unk
 Date: ___/___/___
 Received organ: Yes No Unk
 Date: ___/___/___
 Current pregnancy: Yes No Unk
 Week of gestation: _____
 If infant, breast fed? Yes No Unk

Knowledge of WNV prior to illness:

Did patient do anything to avoid mosquito bites? Yes No Unk
If yes,
 - used insect repellent? Yes No Unk
 - drained standing water near home? Yes No Unk

Other significant history (social, family, etc.):

For questions regarding testing or specimens, call Cynthia Jean (510) 307-8606
 Fax this form to (510) 307-8599 or mail to CDHS VRDL – West Nile Virus, 850 Marina Bay Parkway, Richmond CA 94804