

West Nile Encephalitis Case Investigation Patient Interview Form - St. Louis Region

C A S E	ID Number: _____ Date Case Was Reported: ____/____/____ Date of patient/proxy interview: ____/____/____
	Name of person who completed interview: _____
	Please Check Reason for West Nile Infection Suspicion: <input type="checkbox"/> IgM-capture ELISA on CSF <input type="checkbox"/> 4 fold rise in IgG tier from paired acute/convalescent sera confirmed by PRNT <input type="checkbox"/> Simultaneous presence of IgM and IgG antibodies in serum <input type="checkbox"/> PCR isolation of DNA from CSF, blood, or tissue <input type="checkbox"/> Isolation of WNV on culture of CSF, blood, or tissue <input type="checkbox"/> Serum only
	Date of Specimen Test: ____/____/____

P A T I E N T I N F O	Name: _____ (Last) (First) (MI)
	Address: _____ (Street) (Apt) (City) (County)
	_____ (State) (Zip Code) () (Home Phone) () (Work/Other Phone) (Other Contact Info)
	DOB: ____/____/____ Age: _____ Sex: _____ Race: _____ (W=White, H=Hispanic, B=Black, I=Am Indian, A=Asian, O=Other, if other, please specify)
	Country of Birth: _____ (If born outside US, year arrived in US: _____)

P H Y S I C I A N I N F O	Attending MD Information:
	Name: _____ (Last) (First) (MD or DO)
	Hospital Affiliation: _____ Department: _____ Office Number: () _____
	Primary Care of Private MD Information:
	Name: _____ (Last) (First) (MD or DO)
	Hospital Affiliation: _____ Department: _____ Office Number: () _____
Reporting Institution (if different than above physicians):	
Name: _____ (Last) (First)	
Institution: _____ Office Number: () _____	

I L L N E S S O N S E T	Person interviewed: <u>Patient / Other</u> If Other, Name of Person: _____ Relationship: _____ Telephone contact () _____
	Date of illness onset: ____/____/____ Date three weeks prior to illness onset: ____/____/____
	Explain to patient or proxy the following questions should be answered about the three weeks before illness onset (as determined above).
	8/22/2002 WNV-Patient

RISK EXPOSURE HISTORY

Did the patient travel outside the USA in the three weeks before illness onset? Yes / No / Unknown

If Yes, Countries visited: _____

Date departed from US: ___ / ___ / ___ Date returned to US: ___ / ___ / ___

Did the patient travel outside (insert city/region area) during the three weeks before illness onset? Yes / No / Unknown

If Yes, places visited: _____

Date departed from (city/region): ___ / ___ / ___ Date returned to (city/region): ___ / ___ / ___

Has the patient received a blood transfusion/blood product/organ transplant within the last three weeks? Yes / No / Unknown

If Yes, where was the blood transfusion/blood product/organ transplant? _____ organ type: _____

If Yes, when was the blood transfusion/blood product/organ transplant received? ___ / ___ / ___ (transfusion) ___ / ___ / ___ (transplant)

Has the patient donated blood/plasma/organ/tissue within the last three weeks? Yes / No / Unknown

If Yes, where was the blood/plasma/organ/tissue donated? _____ organ type: _____

If Yes, when did donation occur? ___ / ___ / ___

Is patient employed? Yes / No / Unknown

If Yes, Occupation: _____

Where does he/she work?: _____

If patient spent time outdoors for work or leisure in the three weeks prior to illness onset, approximately how many hours/day spent outdoors: _____

Work Hours	Yes (X)	Leisure Hours	Yes (X)
Dawn		Dawn	
Morning		Morning	
Noon		Noon	
Afternoon		Afternoon	
Dusk		Dusk	
Evening		Evening	

Did the patient spend time in any (insert city/region) city parks, county parks, or Missouri State parks during the three weeks before illness onset? Yes / No / Unknown

If Yes, list park name(s): _____

Did the patient spend time outdoors in any of the following areas during the three weeks before illness onset?

Zoo: Yes / No / Unknown

If Yes, Places visited: _____

Public Garden : Yes / No / Unknown

If Yes, Places visited: _____

Cemetery: Yes / No / Unknown

If Yes, Places visited: _____

Outdoors sport field or stadium: Yes / No / Unknown

If Yes, Places visited: _____

Spending time around the home, such as gardening or sitting outside: Yes / No / Unknown

If Yes, Places visited: _____

Swimming: Yes / No / Unknown

If Yes, Places visited: _____

Camping: Yes / No / Unknown

If Yes, Places visited: _____

Please list all OTHER places patient likely spent time outdoors in the three weeks before illness onset:

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Does the patient recall being bitten by mosquitoes during the three weeks before illness onset? Yes / No / Unknown
If Yes: Often / Sometimes / Rarely
Where was patient when he/she was bitten: _____
What time of day was the patient bitten: _____ What part of the body did the bite occur? _____

Does the patient use mosquito repellent while outdoors? Yes / No / Unknown
If Yes, What brand do they use: _____
How often: Always / Sometimes / Rarely

Does the patient recall seeing dead birds in the three weeks before illness onset? Yes / No / Unknown
If Yes, How many dead birds: _____
Where did patient report seeing dead birds: _____

Did the patient have direct contact with dead bird (touching bird with bare hands)? Yes / No / Unknown

Did the patient have a birdbath in (or near) their home at the time of symptom onset? Yes / No / Unknown
If Yes, Is the water changed routinely? Yes / No / Unknown
Were larvacide tablets added to the water? Yes / No / Unknown

Were there any additional sources of standing water around the home such as tires, flowerpots, or aluminum cans three weeks before symptom onset? Yes / No / Unknown
If Yes, please describe: _____

Does the patient have any pets at home, work, or other location frequently visited? Yes / No / Unknown
If Yes, What type of animal(s)? _____
Were the animals sick and/or died in the last 3 weeks (describe)? _____

Does the patient have air conditioning in their home? Yes / No / Unknown

Does the patient/family recall having left any windows open at home without screens during the three weeks before illness onset? Yes / No / Unknown

Does the patient recall any mosquitoes inside his/her home anytime during the three weeks before illness onset? Yes / No / Unknown

Does the patient smoke currently? Yes / No / Unknown
If Yes, How many packs per day? _____ How many years have you smoked? _____
If No, Has patient ever smoked? Yes / No / Unknown
When patient did smoke, How many packs per day? _____ How many years did he/she smoke? _____

(For persons born in US only)

Has the patient ever traveled outside the United States? Yes / No / Unknown

If Yes, specify countries visited and approximate dates of travel:

_____ Date departed US: ___/___/___ Date returned to US: ___/___/___
(Country(ies) visited)

_____ Date departed US: ___/___/___ Date returned to US: ___/___/___
(Country(ies) visited)

_____ Date departed US: ___/___/___ Date returned to US: ___/___/___
(Country(ies) visited)

_____ Date departed US: ___/___/___ Date returned to US: ___/___/___
(Country(ies) visited)

Has the patient ever served in the military? Yes / No / Unknown
If Yes, during what dates? ___/___/___ to ___/___/___

Has the patient ever received a vaccination against:
Yellow Fever: Yes / No / Unknown If Yes, Date of vaccination: ___/___/___

Japanese Encephalitis virus: Yes / No / Unknown If Yes, Date of vaccination: ___/___/___

Tick-borne Encephalitis (TBE): Yes / No / Unknown If Yes, Date of vaccination: ___/___/___

M E D I C A L H I S T O R Y

Does patient have history of the following conditions prior to onset of illness? Yes / No

If Yes, Please indicate which conditions:

Condition	Present (X)	Condition	Present (X)
Hypertension		Prior viral encephalitis:	
Diabetes		West Nile Encephalitis	
Cardiac disease		St. Louis Encephalitis	
Lung disease		Dengue Fever	
Hepatitis		Japanese Encephalitis	
Pancreatitis		Other flavivirus Please Specify: _____	
Seizures			
Alcohol Abuse			
Cancer			
Asthma			
Status 1			
Other immunocompromising diseases (e.g., post marrow or solid organ transplant, on immunosuppressive drugs for cancer, or high-dose steroids)			

D I S E A S E P R E S E N T A T I O N

Has the patient experienced any of the following symptoms during onset of illness? Yes / No

If Yes, Please indicate which symptoms:

Condition	Present (X)	Condition	Present (X)	Condition	Present (X)
Fever		Nausea		Conjunctivitis (red eyes)	
Headache		Diarrhea		Altered mental status	
Stiff neck		Vomiting		Memory loss	
Photophobia		Abdominal pain		Tremors	
Fatigue		Poor appetite		Slurred speech	
Swollen glands (Lymphnodes)		Urinary symptoms		Unconscious	
Joint pains		Chest pain		Confusion	
Muscle pains		Shortness of breath		Seizures	
Muscle weakness		Cough			
Rash		Sore throat			

What was the patient's condition at time of interview? Recovered / Died / Still in Hospital / Improved but not to baseline prior to illness
Other _____

Was the patient discharged to: Home / Long-term care facility / Still in hospital Other _____