



# MALARIA CASE SURVEILLANCE REPORT

Department of Health and Human Services, Centers for Disease Control and Prevention  
Division of Parasitic Diseases (MS F-22), 4770 Buford Highway, N.E.  
Atlanta, Georgia 30341



State Case No: .....  
DASH No: .....

Case No: .....  
County: .....

Form Approved  
OMB 0920-0009

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| Patient name (last, first):  | Age (yrs): ____ (mos): ____ Sex: Male<br>Date of Birth: ____/____/____ Female  |
| Date of symptom onset of <b>this</b> attack (mm/dd/yyyy): ____/____/____ | Is patient pregnant? Yes No  |
| Physician name (last, first):  | Race/ethnicity:<br>White Asian/Pacific Islander<br>Black American Indian/Alaska Native<br>Hispanic Unknown/Not specified |
| Telephone Number: ( ) _____ - _____                                      |  |

|   |  |
|---|--|
| Lab results:<br>Smear positive Smear Negative No Smear Taken                      | State/ territory reporting this case: _____  |
| Species (check all that apply):<br>Vivax Falciparum Malariae Ovale Not Determined | Patient admitted to hospital: Yes No<br>Hospital: _____<br>Date: ____/____/____ Hospital record #: _____ |

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|---|--|
| Laboratory name:<br>Telephone Number: ( ) _____ - _____ | Specimens being sent to CDC? Yes No<br>If yes: Smears Whole Blood Other: _____ |
|---|--|

Has the patient traveled or lived outside the USA during the past 4 years? Yes No If yes, specify:  
Country: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
Date returned/ arrived in U.S. (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
Duration of stay in foreign country (days): \_\_\_\_\_

|   |  |
|---|--|
| Did patient reside in U.S. prior to most recent travel?<br>Yes, for =>12 months<br>Yes, for <12 months<br>No, (specify country): _____<br>Unknown | Principal reason for travel from/ to U.S. for most recent trip:<br>tourism visiting friends/relatives student/teacher<br>military airline/ ship crew other: _____<br>business missionary or dependent<br>Peace Corps refugee/immigrant |
|---|--|

Was malaria chemoprophylaxis taken? Yes No If yes, which drugs were taken?  
chloroquine mefloquine doxycycline primaquine Malarone™ Other: \_\_\_\_\_

|  |  |
|--|--|
| Were all pills taken as prescribed?<br>Yes, missed no doses<br>No, missed one to a few doses<br>No, missed more than a few but < half of the doses<br>No, missed half or more of the doses<br>No, missed doses but not sure how many<br>Don't know | If doses were missed, what was the reason?<br>Forgot<br>Didn't think needed<br>Had a side effect (specify): _____<br>Was advised by others to stop<br>Prematurely stopped taking once home<br>Other (specify): _____ |
|--|--|

History of malaria in last 12 months (prior to this report)? Yes No  
If yes, species (check all that apply): Vivax Falciparum Malariae Ovale Not Determined  
Date of previous illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

Blood transfusion/transplant within last 12 months: Yes No If yes, date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|   |  |
|---|--|
| Clinical complications for this attack:<br>cerebral malaria ARDS none<br>renal failure anemia other: _____<br>(Hb<11, Hct<33) | Was illness fatal: Yes No Unknown<br>If yes, date of death: ____/____/____ |
|---|--|

Therapy for this attack (check all that apply):  
chloroquine tetracycline/doxycycline mefloquine exchange unknown  
primaquine quinine/quinidine pyrimethamine-sulfadoxine transfusion other (specify): \_\_\_\_\_  
Malarone

Person submitting report: \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
Affiliation: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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