

Dengue Case Report
Georgia Department of Public Health

Patient Information

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____

Zip Code _____ County _____ Telephone _____

Date of Birth _____ Age _____ Years Months Weeks

Gender: Male Race: White Ethnicity: Hispanic or Latino
 Female Black Not Hispanic or Latino
 Unknown American Indian/Alaska Native Unknown
 Asian
 Native Hawaiian or Pacific Islander
 Multi-racial
 Unknown
 Other _____

Country of Birth _____ Duration of visit or live in U.S. _____

Residence Status: U.S. Resident Military Status: Civilian
 Foreign Visitor Active Military
 Expatriate visiting U.S. Unknown
 Unknown

Reporting Information

Reported by
Last Name _____ First Name _____ Title _____

Telephone _____ Hospital/Practice _____

Physician requesting testing (if different than person reported by) _____

Telephone _____ Hospital/Practice _____

Clinical Information

Date of Onset _____

Hospitalized: Yes No Unknown Admission Date: _____

Hospital: _____

Duration of hospitalization (days): _____

ICU Admission: Yes No Unknown

Died: Yes No Unknown Date of Death: _____

Symptoms (select all that apply):

- Documented fever** _____ °F **OR** **Subjective fever**
- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Altered mental status | <input type="checkbox"/> Arthralgia (joint pain) | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ataxia | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Body pain | <input type="checkbox"/> Chills or rigors | <input type="checkbox"/> Conjunctivitis |
| <input type="checkbox"/> Convulsion/coma | <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Fatigue/malaise | <input type="checkbox"/> Headache | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Myalgia | <input type="checkbox"/> Nasal bleeding | <input type="checkbox"/> Nasal congestion |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Pallor/cool skin | <input type="checkbox"/> Paresis/paralysis | |
| <input type="checkbox"/> Parkinsonism or cogwheel rigidity | | <input type="checkbox"/> Petechie | |
| <input type="checkbox"/> Platelets $\leq 100,000/\text{MM}^3$ (platelet count _____) | | | |
| <input type="checkbox"/> Positive urinalysis | <input type="checkbox"/> Purpura/ecchymosis | <input type="checkbox"/> Rash | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Vomit with blood |

- | | |
|--|--|
| <input type="checkbox"/> Acute flaccid paralysis | <input type="checkbox"/> Guillain Barre Syndrome |
| <input type="checkbox"/> Hemorrhage resulting in shock | <input type="checkbox"/> Plasma leakage resulting in acute respiratory failure |
| <input type="checkbox"/> Acute liver failure/hepatitis | <input type="checkbox"/> Acute myocarditis |
| <input type="checkbox"/> Multisystem organ failure | <input type="checkbox"/> Other severe clinical signs _____ |

Pleural or abdominal effusion Yes No

Lowest hematocrit _____

Highest hematocrit _____

Lowest serum albumin _____

Lowest serum protein _____

Lowest blood pressure _____ / _____

Lowest pulse pressure _____
(systolic minus diastolic)

Tourniquet test Pos Neg Not done

Medical History

Did patient **receive** blood or blood products or solid organ(s) within 4 weeks *prior* to illness onset?

Yes No Unknown

Did patient **donate** blood or blood products or solid organ(s) within 2 weeks *prior* to illness onset?

Yes No Unknown

Is the patient pregnant?

Yes No Unknown

Did the patient receive a yellow fever vaccine?

Yes No Unknown

Year vaccinated _____

Has the patient been diagnosed with dengue before? Yes No Unknown

If yes, when? _____

Travel History

Last foreign travel destination (country) _____

Date patient returned to the U.S. _____

Days travelled outside the U.S. _____

Reason for travel (select one):

Tourism

Missionary/Volunteer/Researcher/Aid work

Medical tourism

Peace Corps

Immigration to U.S.

Business

Student

Ecotourism

Visiting friends/relatives

Unknown

Did the patient obtain a pre-travel health consultation prior to this trip?

Yes No Unknown

Second last foreign travel destination (country) _____

Third last foreign travel destination (country) _____

Specimen Information

Serum 1 (Acute)

Collection Date _____

IgM results _____

IgG results _____

Other results _____

Laboratory _____

Serum 2 (Convalescent)

Collection Date _____

IgM results _____

IgG results _____

Other results _____

Laboratory _____

Other specimen

Type of specimen _____

Collection Date _____

IgM results _____

IgG results _____

Other results _____

Laboratory _____