

**Influenza Investigation Form Supplemental Pages**

Patient Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

This supplemental form is for use with the General Influenza Investigation Form. Sections on this supplemental form can be completed as needed.

**BASIC TRAVEL HISTORY**

**Did the case travel in the 10 days prior to illness onset?**  Yes, within state  Yes, out of state  Yes, out of country  No  Unknown

If yes,

Traveled to: \_\_\_\_\_ Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Traveled to: \_\_\_\_\_ Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Traveled to: \_\_\_\_\_ Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

**Did any close contacts of the patient travel in the month prior to patient's illness onset?**  Yes  No  Unknown

If yes,

Name: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Traveled to: \_\_\_\_\_ Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Traveled to: \_\_\_\_\_ Dates of travel: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

**EXTENSIVE TRAVEL HISTORY** (for investigations requiring contact tracing)

**If case travel involved an airline, please provide the following for all flights in the 10 days prior to onset through 24 hours after symptoms end:**

Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Airline: \_\_\_\_\_ Flight number: \_\_\_\_\_

Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Airline: \_\_\_\_\_ Flight number: \_\_\_\_\_

Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Airline: \_\_\_\_\_ Flight number: \_\_\_\_\_

Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Airline: \_\_\_\_\_ Flight number: \_\_\_\_\_

**If case travel involved a bus, please provide the following for all trips in the 10 days prior to onset through 24 hours after symptoms end:**

Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Bus line: \_\_\_\_\_ Bus number: \_\_\_\_\_

Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Bus line: \_\_\_\_\_ Bus number: \_\_\_\_\_

**If case travel involved a cruise line, please provide the following for all trips in the 10 days prior to onset through 24 hours after symptoms end:**

Cruise line: \_\_\_\_\_ Ship: \_\_\_\_\_ Departure date \_\_\_/\_\_\_/\_\_\_ Departure time: \_\_\_\_\_ Return date \_\_\_/\_\_\_/\_\_\_

Departure city: \_\_\_\_\_ Stops: \_\_\_\_\_

**CLOSE CONTACTS**

**How many people live in the patient's household (including the patient)?** \_\_\_\_\_ **How many were/are sick?** \_\_\_\_\_

**Did the patient care for anyone who was sick (10 days before, concurrently or after)?**  Yes  No  Unknown

If yes,

Name: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Date of onset: \_\_\_/\_\_\_/\_\_\_ Symptoms: \_\_\_\_\_

Or, if the case is a health care worker, where do they work: \_\_\_\_\_ Date last worked before onset: \_\_\_/\_\_\_/\_\_\_

**Did any other close contacts of the patient have symptoms (sx) of illness (10 days before, concurrently or after)?**  Yes  No  Unk

If yes,

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Date of onset: \_\_\_/\_\_\_/\_\_\_ Sx: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Date of onset: \_\_\_/\_\_\_/\_\_\_ Sx: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Date of onset: \_\_\_/\_\_\_/\_\_\_ Sx: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to case: \_\_\_\_\_ Date of onset: \_\_\_/\_\_\_/\_\_\_ Sx: \_\_\_\_\_

*If you need to follow up with contacts, use the contact tracking form to collect additional information.*

**EXTRACURRICULAR ACTIVITIES**

**Does the patient participate in any extracurricular group activities (e.g., sports team, social club, etc)**  Yes  No  Unknown

If yes, type of activity/organization: \_\_\_\_\_ Name of organization/team: \_\_\_\_\_

Date last participated: \_\_\_/\_\_\_/\_\_\_ Number of people on team/at meeting: \_\_\_\_\_

Contact name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**SCHOOL / DAYCARE EXPOSURES**

Does the patient attend school and / or a day care?  Yes  No  Unknown

If yes, please check all that apply

Grade school    Grade: \_\_\_\_\_ Name of school: \_\_\_\_\_ Contact name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

University    Name of school: \_\_\_\_\_ Contact name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Day care    Name of day care: \_\_\_\_\_ Contact name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other after school care    Name of facility/program: \_\_\_\_\_ Contact name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Has the school or daycare seen an increase in ILI or other respiratory symptoms among attendees or staff?  Yes  No  Unknown

**ANIMAL EXPOSURES**

Did the patient have any contact (touching or close proximity) with wild or domestic animals within the last month (check all that apply)?

Chickens  Ducks  Pigs (swine)  Turkeys  Other: \_\_\_\_\_

If yes, please describe the contact (when/where/extent) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did the patient visit any of the following locations where animals may be present within the last month (check all that apply)?

Farm  Petting zoo  Agricultural event  Rodeo  Live animal market  Slaughterhouse  Pet store

Other: \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Was the patient exposed to environments contaminated by animal feces (including poultry, wild birds or swine) within the last month?

Yes  No  Unknown

If yes, describe: \_\_\_\_\_

Did the patient touch (handle, slaughter, butcher, prepare for consumption) animals (including poultry, wild birds or swine) or their remains within the last month?

Yes  No  Unknown

If yes, describe: \_\_\_\_\_

Did the patient consume raw or undercooked animals (including poultry, wild birds or swine) within the last month?

Yes  No  Unknown

If yes, describe: \_\_\_\_\_

Are any sick or dead animal(s) present in the patient's home, neighborhood or workplace?

Yes  No  Unknown

If yes, describe: \_\_\_\_\_

**OTHER EXPOSURES**

Did the patient handle specimens/samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

Yes  No  Unknown

If yes, please describe: \_\_\_\_\_

**LONG TERM CARE FACILITY EXPOSURES**

Does the patient live or stay at a long term care facility?  Yes  No  Unknown

If yes, name of facility: \_\_\_\_\_ Is anyone else at the facility symptomatic?  Yes  No  Unknown

Contact name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**ADDITIONAL CLINICAL AND LABORATORY FINDINGS**

Is the patient on chronic drug therapy?  Yes  No  Unknown If yes, what: \_\_\_\_\_ dose/frequency: \_\_\_\_\_

Did the patient have leukopenia (WBC count < 5,000 leukocytes/mm3)?  Yes  No  Unknown

Did the patient have lymphopenia (total lymphocytes <800mm3 or lymphocytes <15% of total WBC)?  Yes  No  Unknown

Did the patient have thrombocytopenia (total platelets <150,000/mm3)?  Yes  No  Unknown

Did the patient have hemoptysis?  Yes  No  Unknown

Did patient have pulmonary/respiratory tract hemorrhage or hemorrhagic pneumonitis?  Yes  No  Unknown

Did the patient have a chest X-ray or CT scan performed?  Yes  No  Unknown

Findings:  Normal  Evidence of pneumonia  Other: \_\_\_\_\_

Did the patient have a CT scan/MRI of the head or brain?  Yes  No  Unknown

Findings:  Normal  Evidence of acute neurologic abnormality  Other: \_\_\_\_\_

Did the patient require mechanical ventilation?  Yes  No  Unknown

**PREGNANCY / POSTPARTUM INFORMATION**

Was the pregnancy considered high risk?  Yes  No  Unknown

Did the mother have any of the following (Check all that apply)?

Hypo or hyperthyroidism  Gestational diabetes  Obesity prior to pregnancy  Gestational hypertension/preeclampsia/Eclampsia

Tobacco use during pregnancy  Hepatic disorder  Substance abuse during pregnancy (e.g. alcohol / illicit drug use)  Psychiatric disorder

If the patient was admitted to the ICU, how many days were spent in the ICU: \_\_\_\_\_  Still in ICU  Unknown

Was the patient given any of the following medications during hospitalization (Check all that apply)?

Antibiotics  Antihypertensives  Vasopressors  Systemic corticosteroids (if checked was it for the mother's health or the infant's)

Nebulized drugs  Antiepileptics  Antiglycemics  Tocolytic agents  Diuretics  Narcotic Analgesic  Sedative / Hypnotic

Antifungal  Other: \_\_\_\_\_  None  Unknown

What is/was the estimated due date? \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of delivery: \_\_\_\_/\_\_\_\_/\_\_\_\_

Where did delivery occur:

Labor and delivery department  Emergency department  Intensive care unit  Home  Other \_\_\_\_\_  Unknown

What was the method of delivery:

Still pregnant  Vaginal  Cesarean, scheduled  Cesarean, emergency  Cesarean, unknown if scheduled/emergency  Unknown

Was this a multiple fetus pregnancy (e.g. twins, triplets)?  Yes, number \_\_\_\_\_  No  Unknown (if yes, please provide info on each infant)

What was the infant's outcome?  Survived  Stillbirth  Spontaneous abortion  Died within 8 weeks of birth  Unknown

What was the gestational age (weeks) at delivery? \_\_\_\_\_  Unknown

What was the infant's birth weight? \_\_\_\_\_  Unknown

Did the infant have any of the following during hospitalization (Check all that apply)?

Rash  Fever  Temperature instability  Bradycardia  Apnea  Petechiae  Chorioretinitis  Cataracts  Seizures

Meningitis  Other neurologic abnormality, specify \_\_\_\_\_  Hearing loss  Pneumonia  Sepsis

Respiratory distress, specify cause \_\_\_\_\_  Hypoglycemia  Hyperbilirubinemia/Jaundice

Other \_\_\_\_\_  Other \_\_\_\_\_

Was the infant diagnosed with influenza?  Yes  No  Unknown

Did the infant have any influenza tests done?  Yes  No  Unknown

If yes, test<sup>1</sup> \_\_\_\_\_ result<sup>1</sup> \_\_\_\_\_; test<sup>2</sup> \_\_\_\_\_ result<sup>2</sup> \_\_\_\_\_

**NOTES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_