Patient's Name _____ Telephone No. _____ TOXIC - SHOCK SYN

Address _____ (Detach top portion he

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

TOXIC - SHOCK SYNDROME CASE REPORT

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

FORM APPROVED
OMB NO. 0920-0009

The First Three Letters of Patient's Last Name (1-3) ☐☐☐

CDC No. (4-8) ☐☐☐☐☐

State No. (9-10) ☐☐

State Case No. (11-15) ☐☐☐☐☐

Age (16-17) ☐☐

Date of Birth Mo. (18-19) ☐☐ Day (20-21) ☐☐ Yr. (22-23) ☐☐

Sex (24)
Male ☐ 1
Female ☐ 2

Outcome (25)
Lived ☐ 1
Died ☐ 2

Race/Ethnicity (26)
☐ 1 White (not Hispanic)
☐ 2 Black (not Hispanic)
☐ 3 Hispanic
☐ 4 Asian/Pacific Islander
☐ 5 American Indian/Alaskan Native
☐ 9 Not Specified

Date of Onset of Symptoms Mo. (27-28) ☐☐ Day (29-30) ☐☐ Yr. (31-32) ☐☐

Date of Onset of Coincident Menstrual Period (If applicable) Mo. (33-34) ☐☐ Day (35-36) ☐☐ Yr. (37-38) ☐☐

Admitted to Hospital (39)
Yes ☐ 1
No ☐ 2
Unk ☐ 9

Date of Hospital Admission Mo. (40-41) ☐☐ Day (42-43) ☐☐ Year (44-45) ☐☐

CASE CLASSIFICATION (46)
Menstruation-associated ☐ 1
Wound-associated ☐ 2
Postpartum-associated ☐ 3
Other ☐ 4 (specify) _____
No. days postpartum ☐☐ (47-48)

CLINICAL FINDINGS Major Criteria

Fever (highest-if not recorded, leave blank) ☐☐☐.☐ F (49-52)

Hypotension (lowest) Systolic ☐☐☐ (53-55) Diastolic ☐☐ (56-57)

Syncope Yes ☐1 No ☐2 (58)

Orthostatic dizziness Yes ☐1 No ☐2 (59)

Rash (60) Yes ☐1 No ☐2 Unk. ☐9 (61) If yes, Generalized ☐1 Focal ☐2 Describe: _____

Desquamation (62) Yes ☐1 No ☐2 Unk. ☐9 If yes, describe: _____

SIGNS AND SYMPTOMS (First 4 Days of Illness)

	YES 1	NO 2	UNK 9
(63) Vomiting	☐	☐	☐
(64) Diarrhea	☐	☐	☐
(65) Abdominal pain	☐	☐	☐
(66) Myalgia	☐	☐	☐
(67) Sore throat	☐	☐	☐
(68) Conjunctival hyperemia	☐	☐	☐
(69) Oropharyngeal hyperemia	☐	☐	☐
(70) Injected tongue	☐	☐	☐
(71) Vaginal hyperemia	☐	☐	☐
(72) Vaginal discharge	☐	☐	☐
(73) Vaginal ulceration	☐	☐	☐
(74) Disorientation	☐	☐	☐
(75) Seizures	☐	☐	☐
(76) Cardiac Arrhythmia	☐	☐	☐

If Yes, describe _____

LABORATORY DATA (Most Abnormal Values in First 4 Days of Illness)

		Not Obtained
WBC Count (77-79)	☐☐.☐ 000/mm³	(80) ☐
(81-82) Neutrophils	☐☐ %	(83) ☐
(84-85) Bands	☐☐ %	(86) ☐
(87-88) Metamyelocytes	☐☐ %	(89) ☐
(90-91) Myelocytes	☐☐ %	(92) ☐
(93-95) Platelets	☐☐☐ 000/mm³	(96) ☐
(97-99) Highest platelet value after 7 days of illness	☐☐☐ 000/mm³	
(100-102) SGOT	☐☐☐ IU/L	(103) ☐
(104-106) SGPT	☐☐☐ IU/L	(107) ☐
(108-110) Alkaline phosphatase	☐☐☐ IU/L	(111) ☐
(112-114) Bilirubin	☐☐.☐ mg/dl	(115) ☐
(116-119) Amylase	☐☐☐☐ Somogyi Units/dl	(120) ☐

Urinalysis

		Not Obtained
(121-122) WBC/HPF	☐☐ ("Many" = 99)	(123) ☐
(124-125) RBC/HPF	☐☐ ("Many" = 99)	(126) ☐
(127) Protein (0-4+)	☐	(128) ☐
(129-130) BUN	☐☐ mg/dl	(131) ☐
(132-134) Creatinine	☐☐.☐ mg/dl	(135) ☐
(136-138) Calcium	☐☐.☐ mg/dl	(139) ☐
(140-141) Phosphorus	☐.☐ mg/dl	(142) ☐
(143-144) Albumin	☐.☐ g/dl	(145) ☐
(146-149) Creatine phosphokinase (CPK)	☐☐☐☐ IU/L	(150) ☐
(151) CPK-myocardial band	Yes ☐1 No ☐2 Unk ☐9	(152) ☐

(153) EKG Normal ☐1 Abnormal ☐2 Not obtained ☐3 Unk. ☐9 If Abnormal, describe _____

(154) Chest X-Ray Normal ☐1 Abnormal ☐2 Not obtained ☐3 Unk. ☐9 If Abnormal, describe _____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, sea
burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; AT

DROME CASE REPORT

e before sending to CDC.)

Physician's Name _____ Telephone No. _____

Address _____

CULTURES

BLOOD (155) Positive ☐ 1 Negative ☐ 2 Not Done ☐ 3 Unk ☐ 9 **If Positive,** what organism(s): 1 _____ (156-157) 2 _____ (158-159)

URINE (160) Positive ☐ 1 Negative ☐ 2 Not Done ☐ 3 Unk ☐ 9 **If Positive,** what organism(s): 1 _____ (161-162) 2 _____ (163-164)

Colony Count 1. ☐☐☐ 000/ml (165-167) 2. ☐☐☐ 000/ml (168-170)

THROAT (171) Normal Flora ☐ 1 Abnormal ☐ 2 Not Done ☐ 3 Unk ☐ 9 **If Abnormal,** what organism(s): 1. _____ (172-173) 2. _____ (174-175)

NARES (176) Done ☐ 1 Not Done ☐ 3 Unk ☐ 9 **If Done,** what organism(s): 1. _____ (177-178) 2. _____ (179-180)

VAGINA (181) Done ☐ 1 Not Done ☐ 3 Unk ☐ 9 **If Done,** what organism(s): 1. _____ (182-183) 2. _____ (184-185)

Was *Staphylococcus aureus* present in the vagina? (186) **Yes** ☐ 1 **No** ☐ 2 **Unk** ☐ 9

If *S. aureus* present in vagina, is it resistant to penicillin and ampicillin only? (187) **Yes** ☐ 1 **No** ☐ 2 **Unk** ☐ 9

Other Site(s) _____ (188-189) **Organism(s)** 1. _____ (190-191) 2. _____ (192-193)

Was patient taking antibiotics when culture(s) performed? (194) **Yes** ☐1 **No** ☐2 **Unk.** ☐9 **If yes, which sites?** _____ (195-196)

TAMPON/NAPKIN/MINIPAD USE – IF APPLICABLE (During Period When Patient Became Ill)

PRODUCTS USED (197-198)

Tampon only ☐ 1 Minipad only ☐ 3 Tampon and Minipad ☐ 5 Tampon, Napkin, and Minipad ☐ 7 Other _____ (199-200) ☐ 10

Napkin only ☐ 2 Tampon and Napkin ☐ 4 Napkin and Minipad ☐ 6 Sea Sponge ☐ 8 Unknown ☐ 9

(If Only One Brand Was Used Before Onset of Symptoms, List Only That Brand)

BRAND # 1 (Most frequently used, judged by time)

NAME (201-202)

Assure	☐ 1
Kotex	
Plastic Inserter	☐ 2
Stick Inserter	☐ 3
Inserter Unk	☐ 4
o.b.	☐ 5
Playtex	
Deodorized	☐ 6
Non-deodorized	☐ 7
Deodorant unk	☐ 8
Pursettes	☐ 10
Rely	☐ 11
Tampax	☐ 12
Other(specify) _____	☐ 13
Unknown	☐ 9

STYLE(ABSORBENCY) (203)

Super-plus	☐ 1
Super	☐ 2
Regular	☐ 3
Junior	☐ 4
Unknown	☐ 9

BRAND # 2

NAME (204-205)

Assure	☐ 1
Kotex	
Plastic inserter	☐ 2
Stick inserter	☐ 3
Inserter unk	☐ 4
o.b.	☐ 5
Playtex	
Deodorized	☐ 6
Non-deodorized	☐ 7
Deodorant unk	☐ 8
Pursettes	☐ 10
Rely	☐ 11
Tampax	☐ 12
Other (specify) _____	☐ 13
Unknown	☐ 9

STYLE(ABSORBENCY) (206)

Super-plus	☐ 1
Super	☐ 2
Regular	☐ 3
Junior	☐ 4
Unknown	☐ 9

Was Brand No. 1 the only tampon brand used during period when patient became ill? (207)

Yes ☐1 **No** ☐2 **Unk.** ☐9

NAPKIN BRAND: _____ (208-209)

MINIPAD BRAND: _____ (210-211)

How was information in this section verified? (212)

Patient's Memory ☐ 1

Patient viewing product box ☐ 2

Interviewer viewing product box ☐ 3

Other (describe) ☐ 4

RECURRENCE INFORMATION FOR MENSTRUATION - ASSOCIATED CASES

Has patient had similar illness in past during menstrual period? (213) **Yes** ☐1 **No** ☐2 **Unk.** ☐9 **If yes,** how many episodes? (214) One ☐1 Two ☐2 Three ☐3 More than Three ☐4

OTHER INFORMATION

Please describe any other pertinent or unusual features of this case _____

How was case reported to Health Department? (215) By patient or relative ☐1 By physician ☐2 By hospital ☐3 Other ☐4

Person Completing Form	Date Reported to Health Department (216-221)	Date Form Completed (222-227)

FOR CDC USE ONLY ☐1 ☐2 ☐3 ☐4 (228)

ing existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this
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