Maryland Department of Health and Mental Hygiene

E. COLI 0157:H7 CASE HISTORY REPORT

I. DEMOGRAPHIC INFORMATION

1. Last Name-
First Name-

Home Phone ( ) _____-_____

Work Phone ( ) _____-_____

Street Address:

5. County

6. Sex: ☐ Male ☐ Female ☐ Unknown

7. Date of Birth ____/___/___ or Age: _____ years or Age: _____ months
Mo Day Yr

2. City:

3. State: ____ ____

4. Zip Code: ____ ____ ____ ____ ____

8. Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Unknown

9. Race (check all that apply):
☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ White
☐ Black/African American ☐ Other
☐ Unknown

II. ISOLATE INFORMATION

10. Source of Specimen: ☐ Stool (whole, stool swab, rectal swab)
☐ Other (specify): _____

11. Date of Specimen: ____/____/____

12. Was identification of the O157 serogroup confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control?
☐ Yes ☐ No ☐ Unknown

13. Was identification of the H7 serotype confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control?
☐ Yes ☐ No ☐ Unknown

14. This case reported by:
☐ Hospital lab ☐ Infection Control Practitioner
☐ Other lab ☐ School
☐ Physician ☐ Other (specify): _____

Reporting laboratorian's name: _____

Telephone: ( ) _____-_____

Physician's name: _____

Telephone: ( )_____-_____

III. CLINICAL INFORMATION

15. Date of Illness Onset:
____/____/____ ☐ Unknown

16. Did patient have:(please check one answer for each)

	Yes	No	Unknown
Diarrhea	☐	☐	☐
Visible blood in stools	☐	☐	☐
Fever (or felt feverish)	☐	☐	☐
Abdominal cramps	☐	☐	☐

17. Was patient admitted overnight to a hospital for this illness?

☐ Yes ☐ No ☐ Unknown

If yes, name the hospital: _____

18. Did the patient:(please check one answer for each)

	Yes	No	Unknown
have Hemolytic Uremic syndrome? (HUS -hemolytic anemia, low platelet count, kidney impairment)	☐	☐	☐
have Thrombotic Thrombocytopenic Purpura? (TTP is hemolytic anemia, low platelet count, kidney impairment, central nervous system involvement, fever)	☐	☐	☐
undergo dialysis?	☐	☐	☐
have surgery?	☐	☐	☐
die?	☐	☐	☐

IV. PUBLIC HEALTH INFORMATION

19. Does the patient attend or work in:

	Yes	No	Unknown
A child day care center?	☐	☐	☐
An institution?	☐	☐	☐

If yes, where: _____

20. Is the patient usually employed as:

	Yes	No	Unknown
a health care worker?	☐	☐	☐
a food handler?	☐	☐	☐

If yes, where:_____

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V. EPIDEMIOLOGIC INFORMATION

21. In the 7 days before the illness began, did the patient eat at:

	Yes	No	Unknown
A fast food restaurant?	☐	☐	☐
Another restaurant?	☐	☐	☐

If yes, name and location of restaurant(s):

_____
_____
_____
_____
_____
_____

22. In the 7 days before the illness began, did the patient eat or drink any of the following items at home, in a restaurant, or in any other place?

	Yes	No	Unknown
Raw (unpasteurized) milk	☐	☐	☐
Other dairy products made from (unpasteurized) milk	☐	☐	☐
Well water	☐	☐	☐
Other unchlorinated water	☐	☐	☐
Apple cider	☐	☐	☐
Any ground beef or hamburger	☐	☐	☐
Any steak or roast beef	☐	☐	☐
Pink or red steak or roast beef	☐	☐	☐

23. In the 7 days before the illness began, did the patient:

	Yes	No	Unknown
Visit or live on a farm?	☐	☐	☐
Have contact with any cows or cattle?	☐	☐	☐
Touch any cow manure?	☐	☐	☐
Have contact with any children who attend a day care center?	☐	☐	☐
Change any diapers?	☐	☐	☐
Have contact with any children who use diapers?	☐	☐	☐
Go swimming ? If yes, where?	☐	☐	☐
Travel to another state? If yes, where? _____	☐	☐	☐
Travel to another country? If yes, where? _____	☐	☐	☐

24. Did anyone else in the patient's home have diarrhea raw in the 7 days before this patient's illness began?
☐ Yes ☐ No ☐ Unknown

If yes, please obtain the following information:

Name	Age	Sex	Bloody Stools? Yes	No	Unk
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

25. Does the patient know anyone else who has had a similar illness in the past 3 weeks? ☐ Yes ☐ No ☐ Unknown

If yes, please obtain names of persons with similar illness:

_____
_____
_____

26. Did this case occur as part of an outbreak (two or more cases of *E. Coli* O157:H7 infection association by time and place)?
☐ Yes ☐ No ☐ Unknown
If yes, please describe:

_____
_____
_____

VI. ADDITIONAL EPIDEMIOLOGIC INFORMATION OR COMMENTS

_____
_____
_____

VII. DATA COLLECTOR INFORMATION

Person Completing This Form:	Agency:	Phone number: ( ) _____ - _____	Date: ____ / ____ / _____

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