Coccidioidomycosis Report Form

Print Form

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | **Age** | ☐ Years ☐ Months ☐ Days | **Gender** ☐ Male ☐ Female

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** *(mm/dd/yyyy)* | **Country of Birth**

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other *(specify):* _____
☐ Filipino ☐ Laotian
☐ Pacific Islander *(check all that apply)*
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other *(specify):* _____
☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational/Setting ☐ Agriculture ☐ Construction ☐ Petroleum/Oil ☐ Transportation ☐ Landscaping/gardener
☐ Correctional Facility (CF) → (☐ Inmate or ☐ CF Employee)
☐ Student ☐ Retired ☐ Unemployed ☐ Other *(specify):*

COCCIDIOIDOMYCOSIS CLINICAL INFORMATION

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | **City** | **State** | **ZIP Code**

Date of Onset *(mm/dd/yyyy)* | **Date of First Specimen Collection** *(mm/dd/yyyy)* | **Date of Diagnosis** *(mm/dd/yyyy)* | **Outcome** ☐ Recovered ☐ Fatal — If fatal, DOD (mm/dd/yyyy) _____

Hospitalized ☐ Yes ☐ No | **Admit Date**(mm/dd/yyyy) | **Discharge Date** *(mm/dd/yyyy)* | **Hospital Name** | **MR #**

Reason for performing cocci laboratory testing:
☐ Screening ☐ Symptomatic *(check all that apply)* →
☐ Fatigue ☐ Headache ☐ Myalgia ☐ Cough ☐ Hemoptysis ☐ Erythema Multiforme
☐ Fever ☐ Arthralgia ☐ Dyspnea ☐ Chest Pain ☐ Erythema Nodosum
☐ Other:

Laboratory Findings*(Check all positive findings cocci findings)*
EIA-Blood ☐ IgM ☐ IgG Immunodiff.-Blood ☐ IgM ☐ IgG Comp. Fix.-Blood ☐ Pos titer _____ ☐ Other diagnostic test (specify):
EIA-CSF ☐ IgM ☐ IgG Immunodiff.-CSF ☐ IgM ☐ IgG Comp. Fix.-CSF ☐ Pos titer _____
☐ Histopathologically diagnosed ☐ Culture (specify tissue): _____

Radiology *(Check all positive findings cocci findings)*
☐ Chest X-ray (specify): _____ ☐ Other (specify): _____
☐ CT (specify): _____

Treatment (anti-fungal) given at time of diagnosis

	Drug Name	Rx Start Date	Drug Name	Rx Start Date
1.			2.	

EXISTING MEDICAL CONDITIONS/PAST MEDICAL HISTORY

At the time of disease onset did the patient have any immunocompromising condition(s)
☐ No ☐ Unk ☐ Yes *(check all that apply)* →
☐ Cancer → Cancer type (specify): _____
☐ Chemotherapy ☐ CVD ☐ Tuberculosis
☐ COPD/Emphys ☐ Organ Recipient ☐ Corticosteroid Treatment
☐ Asthma ☐ Hepatitis C ☐ Diabetes
Other immunocompromising condition or medications (specify): _____

EXTRAPULMONARY SPREAD

At the time of disease onset did the patient have any evidence of dissemination?
☐ No ☐ Unk ☐ Yes *(check all that apply)* →
☐ Meningitis/encephalitis → **Initial CSF Findings** Date (mm/dd/yyyy) _____
☐ Skin/Soft tissue
☐ Joint (specify): _____
☐ Bone (specify): _____
Other site (specify): _____
RBC _____ Protein _____
WBC _____ Glucose _____
% Diff _____

COCCIDIOIDOMYCOSIS RISK FACTORS

Patient's
Height _____ (ft) _____ (in) →
Weight _____ (lbs)

Any form of tobacco use (past or present)? ☐ Yes ☐ No ☐ Unk _____ ***Weekly*** ☐ Current smoker
Any form of alcohol use (past or present)? ☐ Yes ☐ No ☐ Unk ☐ Current drinker
Any form of drug abuse (past or present)? ☐ Yes ☐ No ☐ Unk ☐ Current drug abuse
→ ***If yes,specify type:*** _____