

West Nile Virus (WNV) Infection Case Report
SUPPLEMENTAL INVESTIGATION FORM

Date Form Completed: ___/___/___

Beginning in 2008, the Centers for Disease Control and Prevention (CDC) will collect surveillance data on selected underlying medical conditions and therapies that have previously been identified as risk factors for severe illness, hospitalization, and/or death among persons with WNV disease. Initial reports of WNV infections should be sent to the California Department of Public Health immediately after they have been confirmed. However, this supplemental investigation form is not time-sensitive and can be submitted at any time after a case has been reported.

Questions to Assess Underlying Medical Conditions and Medication Use

Patient Name (Last, First): _____ **DOB:** ___/___/___

Clinical syndrome: Neuroinvasive disease West Nile fever Other clinical Asymptomatic infection

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

- | | | | |
|---|------------------------------|-----------------------------|----------------------------------|
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| High blood pressure (hypertension) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Heart attack (myocardial infarction) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Angina or coronary artery disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Congestive heart failure (CHF) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Chronic obstructive pulmonary disease (COPD) .. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Chronic liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Kidney failure or chronic kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Bone marrow transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Solid organ transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

If yes: What organ was transplanted?: _____

What year was the transplant?: _____

Cancer

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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If yes: What type(s): _____

What year were you diagnosed?: _____

Are you currently being treated for cancer?: Yes No Unknown

2. Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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If yes: What condition(s): _____

3. At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?

- | | | | |
|--|------------------------------|-----------------------------|----------------------------------|
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Other treatments for cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Hemodialysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Other treatments for kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Oral or injected steroids (not inhaled or topical) ... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Insulin or other medications to treat diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications to treat high blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications to treat coronary artery disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications to treat congestive heart failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Medications that suppress the immune system | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

4. Which of the following sources provided the information above? (check all that apply)

Patient Yes No Family member/friend Yes No

Provider Yes No Medical record Yes No

FAX this form: (951) 358-5102 or 358-5446 for questions call Disease Control at (951) 358-5107 after hours (951) 782-2974