NC Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

MONKEYPOX

CONFIDENTIAL COMMUNICABLE DISEASE REPORT – PART 2

ATTENTION Local Health Department Staff. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias

Birthdate (mm/dd/yyyy): / /	SSN:	Gender: ☐ M ☐ F ☐ M to F ☐ F to M

Patient Street Address	City	State	ZIP	County	Phone ( ) -

Occupation	Employer Name	Business or industry

NC EDSS LAB RESULTS – Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name –City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, earliest (1st) symptom onset date (mm/dd/yyyy): __/__/____
Fever ☐ Y ☐ N ☐ U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature____
Fever onset date (mm/dd/yyyy): __/__/____
Fatigue or malaise or weakness ☐ Y ☐ N ☐ U
Sweats (diaphoresis) ☐ Y ☐ N ☐ U
Night sweats ☐ Y ☐ N ☐ U
Chills or rigors ☐ Y ☐ N ☐ U
Swollen lymph nodes (lymphadenopathy or lymphadenitis) ☐ Y ☐ N ☐ U
Distribution
☐ Cervical (neck), right ☐ Cervical (neck), left
☐ Axillary (armpit), right ☐ Axillary (armpit), left
☐ Inguinal (groin), right ☐ Inguinal (groin), left
Tenderness
☐ Tender ☐ Non-tender
Headache ☐ Y ☐ N ☐ U
Encephalopathy ☐ Y ☐ N ☐ U
Muscle Aches / pains(myalgias) ☐ Y ☐ N ☐ U

Skin rash ☐ Y ☐ N ☐ U
Onset date (mm/dd/yyyy): __/__/____
Observed by health care provider ☐ Y ☐ N ☐ U
Duration:_____
Unit: ☐ Hours ☐ Days ☐ Weeks
Appearance **(select all that apply)**
☐ Macular ☐ Pustular ☐ Bullous ☐ Unknown
☐ Papular ☐ Vesicular ☐ Petechial
Further appearance of rash
☐ Discrete ☐ Confluent ☐ Unknown
Date last scab fell off (mm/dd/yyyy): __/__/____
Total number of lesions
☐ 1-9 ☐ 10-49 ☐ 50-99 ☐ ≥100
Specify body region(s) where the rash occurred
(Select all that apply)
☐ Pelvis/groin/buttocks/hip ☐ Arms
☐ Face ☐ Palm of hands
☐ Head ☐ Soles of feet
☐ Mouth, lips, or oral mucosa ☐ Genitals
☐ Eyes or eyelids ☐ Perianal
☐ Neck ☐ Other
☐ Trunk ☐ Unknown
Conjunctivitis ☐ Y ☐ N ☐ U
Corneal ulcer(s) or keratitis ☐ Y ☐ N ☐ U
Runny nose and/or teary eyes(coryza) ☐ Y ☐ N ☐ U
Sore throat ☐ Y ☐ N ☐ U

Airway compromised due to lymphadenitis ☐ Y ☐ N ☐ U
Cough ☐ Y ☐ N ☐ U
Shortness of breath / difficulty breathing / respiratory distress ☐ Y ☐ N ☐ U
Nausea ☐ Y ☐ N ☐ U
Vomiting ☐ Y ☐ N ☐ U
Abdominal pain or cramps ☐ Y ☐ N ☐ U
Tenesmus (urgency to defecate) ☐ Y ☐ N ☐ U
Rectal pain ☐ Y ☐ N ☐ U
Rectal bleeding ☐ Y ☐ N ☐ U
Pus or blood in stools ☐ Y ☐ N ☐ U
Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐ Y ☐ N ☐ U
If yes, please specify _____

PREDISPOSING CONDITIONS/ COMORBID CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U
If yes, please specify _____
Injury/Wound/Break in skin ☐ Y ☐ N ☐ U
Anatomic site _____
Circumstances _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy): / /			SSN:		

PREGNANCY

Is the patient currently pregnant? .. ☐ Y ☐ N ☐ U
Estimated delivery date (mm/dd/yyyy): __/__/____
Actual delivery date (mm/dd/yyyy): __/__/____
Number of weeks gestation at onset of illness____
Trimester of gestation at onset of illness
☐ First ☐ Second ☐ Third ☐ Unknown
Has the patient been pregnant in the past 12 months? ..... ☐ Y ☐ N ☐ U

INFANT BIRTH DETAILS

If patient was pregnant during the 21 days prior to onset of symptoms, give infant birth details:
Where was the child born?
☐ Hospital ☐ Other
☐ Home ☐ Unknown
Hospital or facility where child was born:
_____
Infant gestational age at birth:
☐ Full term ☐ Premature ☐ Unknown
Birth weight _____
Number of weeks gestation _____
Vital status:
☐ Born alive and still alive
☐ Born alive and then died
☐ Stillborn
☐ Fetal death/spontaneous abortion
☐ Unknown
Date of child death (mm/dd/yyyy): __/__/____
Give cause(s) of death from death certificate:
_____
_____
Was an autopsy performed? ... ☐ Y ☐ N ☐ U
If yes, give final pathological diagnosis:
_____
_____

TREATMENT

Did this patient receive anti-orthopoxviral treatment?..... ☐ Y ☐ N ☐ U
Specify antiviral name:
☐ Brincidofovir (CMX001, Tembexa)
☐ Cidofovir (Vistide)
☐ Tecovirimat (TPOXX, ST-246)
☐ Other, specify:
Date antiviral treatment began(mm/dd/yyyy): __/__/____
Treatment Notes:
_____
_____
_____
_____

HEALTHCARE INFORMATION

Was the patient hospitalized for this illness > 24 hours? ..... ☐ Y ☐ N ☐ U
Hospital name: _____
City, State: _____, _____
Hospital contact name: _____
Phone: (___) ___-____
Admit date (mm/dd/yyyy): __/__/____
Discharge date (mm/dd/yyyy): __/__/____
Medical record number for this hospitalization:
_____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restriction to movement or freedom of action (i.e. work, child care, school, etc.)? ..... ☐ Y ☐ N
Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School
☐ Other: _____
Date control measure issued(mm/dd/yyyy): __/__/____
Date control measure ended(mm/dd/yyyy): __/__/____
Was patient compliant with control measures?..... ☐ Y ☐ N ☐ U
Did the local health director or designee implement additional control measures?..... ☐ Y ☐ N
If yes, please specify _____
_____
Were written isolation orders issued?..... ☐ Y ☐ N ☐ U
If yes, where was the patient isolated? _____
_____
Date isolation started (mm/dd/yyyy): __/__/____
Date isolation ended (mm/dd/yyyy): __/__/____
Was patient compliant with isolation? ..... ☐ Y ☐ N ☐ U
Were written quarantine orders issued?..... ☐ Y ☐ N ☐ U
If yes, where was the patient quarantined? _____
_____
Date quarantine started (mm/dd/yyyy): __/__/____
Date quarantine ended (mm/dd/yyyy): __/__/____
Basis for quarantine:
☐ Voluntary
☐ Mandatory by order of state or local health dept.
Was patient compliant with quarantine? ..... ☐ Y ☐ N ☐ U
Comments on isolation and quarantine only:
_____
_____
_____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____
_____
Clinical outcome:
☐ Survived ☐ Died
Died from this illness..... ☐ Y ☐ N ☐ U
Patient died in NC..... ☐ Y ☐ N ☐ U
County of death: _____
Autopsy performed..... ☐ Y ☐ N ☐ U
Patient autopsied in NC..... ☐ Y ☐ N ☐ U
County of autopsy: _____
Date of death (mm/dd/yyyy): __/__/____
Source of death information **(select all that apply)**:
☐ Death certificate
☐ Autopsy report final conclusions
☐ Hospital/discharge physician summary
☐ Other

TRAVEL/IMMIGRATION

The patient is:
☐ Resident of NC
☐ Resident of another state or US territory
☐ Foreign Visitor ☐ Recent Immigrant
☐ Refugee ☐ Foreign Adoptee
☐ None of the above

In the 21 days prior to illness onset, did the patient have any travel history? ..... ☐ Y ☐ N ☐ U
List travel dates (mm/dd/yyyy) and destinations:
From __/__/____ to __/__/____
_____
_____
_____
_____

Mode(s) of transportation (check all that apply):
☐ Airplane ☐ Bus / taxi / shuttle
☐ Ship / boat / ferry ☐ Train / subway
☐ Automobile / motorcycle ☐ On foot
☐ Other, specify:

Additional Travel/Residency information:
_____
_____
_____
_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy): / /			SSN:		

CHILD CARE/SCHOOL/COLLEGE

Does patient attend child care?... ☐ Y ☐ N ☐ U

In what county is child care center located: _____

Name of child care provider: _____

Is patient a child care worker/ volunteer?..... ☐ Y ☐ N ☐ U

In what county is child care center located: _____

Name of child care provider: _____

Is patient a student?..... ☐ Y ☐ N ☐ U

In what county is school located: _____

Type of school:

- ☐ NC public school (preK-12)
- ☐ NC private school (preK-12)
- ☐ Other school (preK-12)
- ☐ Community College
- ☐ College/University
- ☐ Other academic institution (trade school, professional)

Name of school:

_____

Is patient a school worker/ volunteer?..... ☐ Y ☐ N ☐ U

In what county is school located: _____

Type of school:

- ☐ NC public school (preK-12)
- ☐ NC private school (preK-12)
- ☐ Other school (preK-12)
- ☐ Community College
- ☐ College/University
- ☐ Other academic institution (trade school, professional)

Name of school:

_____

BEHAVIORAL RISK AND CONGREGATE LIVING

CONGREGATE LIVING

During the period of interest, did the patient stay in any congregate living facilities or other locations that were not their primary residence? ..... ☐ Y ☐ N ☐ U

If yes, please specify facility **(select all that apply)**:

- ☐ Correctional facility
- ☐ Barracks
- ☐ Shelter
- ☐ Dormitory, sorority, fraternity
- ☐ Other, specify:
- ☐ Commune
- ☐ Boarding school
- ☐ Camp

Name of facility or intuition: _____

_____

_____

Start date (mm/dd/yyyy): / /

End date (mm/dd/yyyy): / /

During the period of interest, has the patient attended any social gatherings or crowded settings?..... ☐ Y ☐ N ☐ U

If yes, please specify setting(s): _____

_____

_____

SEXUAL RISK

During the period of interest, has the patient had sexual contact with a *FEMALE*? ..... ☐ Y ☐ N ☐ U

Specify number of female sexual partners during period of interest: _____

During the period of interest, has the patient had sexual contact with a *MALE*?..... ☐ Y ☐ N ☐ U

Specify number of male sexual partners during period of interest: _____

During the period of interest, has the patient had sexual contact with a *PERSON OF OTHER GENDER IDENTITY*? ..... ☐ Y ☐ N ☐ U

Specify number of partners of other gender identity during period of interest: _____

During the period of interest, did the patient meet sexual partners on the Internet/apps? .... ☐ Y ☐ N ☐ U

Specify sites the has patient used: _____

_____

_____

Total number of internet sex partners: _____

During the period of interest, did the patient meet a partner at a bar or a club?..... ☐ Y ☐ N ☐ U

During the period of interest, did the patient have sex at a sex party? ..... ☐ Y ☐ N ☐ U

During the period of interest, did the patient trade sex for drugs or money? ..... ☐ Y ☐ N ☐ U

SUBSTANCE USE

During the period of interest, did the patient use injection drugs? ..... ☐ Y ☐ N ☐ U

Indicate drug(s) used **(check all that apply)**:

- ☐ Cocaine
- ☐ Crack
- ☐ Heroin
- ☐ Narcotics/Opioids
- ☐ Other, specify:
- ☐ Methamphetamine
- ☐ Stimulants
- ☐ Not specified

During the period of interest, did the patient use NON-injection drugs?..... ☐ Y ☐ N ☐ U

Indicate drug(s) used **(check all that apply)**:

- ☐ Alcohol
- ☐ Marijuana
- ☐ Cocaine
- ☐ Crack
- ☐ Heroin
- ☐ Narcotics/Opioids
- ☐ Other, specify:
- ☐ Methamphetamine
- ☐ Stimulants
- ☐ Nitrates/Poppers
- ☐ Erectile dysfunction medications
- ☐ Not specified

HEALTH CARE RISK FACILITY

In the 21 days prior to illness onset, did the patient have any of the following health care exposures?

- ☐ Emergency Department (not hospitalized)
- ☐ Hospitalized
- ☐ Outpatient facility – patient (e.g. urgent care, clinic, physician office)
- ☐ Visitor to health care setting
- ☐ Worked in healthcare or clinical laboratory setting
- ☐ No
- ☐ Unknown

Visit / admit date (mm/dd/yyyy): / /

Facility name: _____

_____

Health care exposure notes:

_____

_____

_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy): / /		SSN:			

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms?..... ☐ Y ☐ N ☐ U

If yes, please specify: __ _____

During the period of interest, did the patient have contact with a known monkeypox case (probable or confirmed)?..... ☐ Y ☐ N ☐ U

If the patient had contact with a known monkeypox case:

What type of contact?

- ☐ Household contact
- ☐ Community-associated contact
- ☐ Work-associated contact
- ☐ Healthcare-associated contact (patient, visitor, healthcare worker)
- ☐ Sexual (e.g., vaginal, oral, or anal sex) or intimate contact (e.g., cuddling, kissing, touching partner's genitals or anus, or sharing sex toys)
- ☐ Other, specify:
- ☐ Unknown

During the period of interest, did the patient have any of the following additional risk exposures? (check all that apply)

- ☐ Sports Team Participation
  - Specify team/affiliation: __ _____
  - Specify type of sport: __ _____
- ☐ Pool or spa
  - Specify name: __ _____
- ☐ Personal Care; eg. Hair salon, massage
  - Specify name: __ _____
- ☐ Hotel / motel
  - Specify name: __ _____
- ☐ Adult Day Care/PACE program
  - Specify name: __ _____
- ☐ Bars, Brewery, or nightclubs
  - Specify name: __ _____
- ☐ Gym or Fitness centers
  - Specify name: __ _____
  - Specify type of fitness activity: __ _____
- ☐ Day Camp
  - Specify name: __ _____
- ☐ Work (if any of these selected risks are work, please ensure work is also selected)
  - Occupation: __ _____
  - Employer name: __ _____
  - Business/Industry: __ _____
- ☐ Other
  - Specify: __ _____
- ☐ None
- ☐ Unknown

Did the patient work with smallpox vaccine or other orthopox vaccine?..... ☐ Y ☐ N ☐ U

If yes, please specify and give details (notes):

____ _____

_____

Did the patient work with monkeypox vaccine or other orthopox vaccine?..... ☐ Y ☐ N ☐ U

If yes, please specify and give details (notes):

____ _____

_____

ANIMAL EXPOSURE

During the period of interest, did the patient have exposure to household pets or other animals (includes animal tissues, animal products, or animal excreta)? ..... ☐ Y ☐ N ☐ U

Did the patient have contact with household pets?..... ☐ Y ☐ N ☐ U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder / wholesaler / distributer?..... ☐ Y ☐ N ☐ U

Did the patient work in animal importation?..... ☐ Y ☐ N ☐ U

Was the patient exposed to wild animals?..... ☐ Y ☐ N ☐ U

Did the patient hunt or trap animals?..... ☐ Y ☐ N ☐ U

Did patient skin / eviscerate (gut) wild animal or contact with wild animal carcass?..... ☐ Y ☐ N ☐ U

Did the patient necropsy animals?..... ☐ Y ☐ N ☐ U

Did patient have contact with commercial animal products (i.e. wool, hair, hides, fur, raw / smoked meat, bones, bone meal)?..... ☐ Y ☐ N ☐ U

Did the patient work at or visit a fair with livestock or a petting zoo?..... ☐ Y ☐ N ☐ U

Did the patient work at or visit a zoo, zoological park, or aquarium?..... ☐ Y ☐ N ☐ U

Did the patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory?..... ☐ Y ☐ N ☐ U

Specify animal(s) and give details:

_____ _____

_____

_____

_____

_____

_____

_____

_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias

Birthdate (mm/dd/yyyy): / /	SSN:

CASE INTERVIEWS / INVESTIGATIONS

Was the patient interview? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): ___/___/_____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed?

- ☐ Employer / supervisor / co-worker
- ☐ Household contact / roommate
- ☐ Friend / neighbor
- ☐ Parent
- ☐ Guardian
- ☐ Other, specify:

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted?

- ☐ Infectious disease physician
- ☐ Physician
- ☐ PA / FNP
- ☐ Other, specify:

Medical record(s) reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Notes on medical record verification:

OUTBREAK

Is the patient part of an outbreak for this disease? ☐ Y ☐ N ☐ U

VACCINE INFORMATION

Has patient / contact every received vaccine related to this disease? ☐ Y ☐ N ☐ U

If yes, number of doses received: __ _____

Vaccine type

- ☐ ACAM2000
- ☐ DryVax (prior to 2008)
- ☐ JYNNEOS
- ☐ Other vaccinia (smallpox) vaccine
- ☐ Other, specify:
- ☐ Unknown vaccine or immune globulin

Date of administration (mm/dd/yyyy): ___/___/_____

Vaccine date unknown ☐ Y ☐ N ☐ U

Source of vaccine information

- ☐ Patient's or parent's verbal report
- ☐ Patient vaccine record
- ☐ Physician
- ☐ School record
- ☐ Medical Record
- ☐ NCIR Record
- ☐ Certificate of immunization record
- ☐ Unknown
- ☐ Other, specify:

Reason for vaccination

- ☐ Pre-exposure
- ☐ Post-exposure
- ☐ Routine pre-exposure
- ☐ Unknown

Notes (including adverse reactions, etc.):