County of Los Angeles Public Health

Acute Communicable Disease Control
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PARASITIC EPIDEMIOLOGIC CASE HISTORY FORM

VCMR ID: _____ Census Tract: _____ Health District: _____

DISEASE: ☐ Cryptosporidiosis ☐ Other:

☐ Amebiasis **OR** ☐ Giardiasis (IF **NO SYMPTOMS, DO NOT** complete Page 2 Epidemiology Risk Factors Section.)

DEMOGRAPHIC INFORMATION

Patient Name-Last	First	Middle Initial	Date of birth	Age	Sex

Address- Number, Street, Apt #	City	State	ZIP Code

Telephone number

Home: Work: Cell:

Race (check one)

☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other:_____

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check one: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other: _____

Case Occupation: _____

If SOS, Employer/School:_____

Address & City:_____

Telephone no:_____

Household member occupation (if SOS): _____

Employer/School:_____

Address & City: _____

Telephone no: _____

DISEASE HISTORY

Onset date	Duration of symptoms (in days)	Date of first positive stool specimen	Was treatment given? ☐ Yes ☐ No	Name of drug(s):

Hospitalized ☐ Yes ☐ No	Admit date	Discharge date	Facility/Hospital Name	Did case die? ☐ Yes ☐ No	Date of death

Symptomatic: ☐ Yes ☐ No ☐ Unk If **NO symptoms for amebiasis and giardiasis**, **DO NOT** complete Page 2 Epidemiology Risk Factors Section.

Acute Diarrhea (< 8 days)	☐ Yes ☐ No ☐ Unk	Bloating	☐ Yes ☐ No ☐ Unk
Chronic Diarrhea (≥ 8 days)	☐ Yes ☐ No ☐ Unk	Gas	☐ Yes ☐ No ☐ Unk
Blood in stool	☐ Yes ☐ No ☐ Unk	Fever (highest temp _____ °)	☐ Yes ☐ No ☐ Unk
Pale, fatty stools	☐ Yes ☐ No ☐ Unk	Fatigue	☐ Yes ☐ No ☐ Unk
Abdominal cramps	☐ Yes ☐ No ☐ Unk	Weight loss (lbs _____)	☐ Yes ☐ No ☐ Unk
Nausea	☐ Yes ☐ No ☐ Unk	Other: _____	

EPIDEMIOLOGIC RISK FACTORS

Has case had any contact with any other case of this disease?
☐ Yes ☐ No ☐ Unk

Gender of sex partners? Check all that apply:
☐ Female ☐ Male ☐ Transgender (M to F) ☐ Transgender (F to M) ☐ Refused ☐ Not Applicable

For Cryptosporidium only: Is case known to be HIV positive? If Yes, send copy of report to HIV Epi Program.
☐ Yes ☐ No ☐ Unk

For Amebiasis only: Was serological test performed to detect extraintestinal involvement? ☐ Yes ☐ No ☐ Unk

If Yes, result: _____

If positive, which organ was affected: _____

Is this case a(n): ☐ Immigrant ☐ Refugee/Asylee ☐ No ☐ Unk

Immigrant: a person born outside the United States who is now a permanent resident, regardless of legal status
Refugee/Asylee: person who is outside their country of nationality and who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution

If Immigrant/Refugee, country of origin (country of person's nationality):	Date entered US

If Refugee/Asylee, list resident country (country where petitioned to enter US):	Dates in resident country

Patient Name (last, first) _____ Date of Birth _____ VCMR ID: _____

EPIDEMIOLOGIC RISK FACTORS - During the month prior to onset of symptoms, did the case:

1. Travel **from** the United States **to** another country? ..... ☐ Yes ☐ No ☐ Unk

   If Yes, what country? _____ Dates of travel: _____ to _____

2. Have contact with pets at home or elsewhere? ..... ☐ Yes ☐ No ☐ Unk

   If Yes, specify type of pet: ☐ Dog ☐ Puppy ☐ Cat ☐ Other _____

   Describe setting: _____ When: _____

3. Have contact with a dog or other pet with diarrhea? ..... ☐ Yes ☐ No ☐ Unk

   When: _____

4. Participate in any of the following (check all that apply): ☐ Camping ☐ Hiking ☐ Swimming ☐ Fishing ☐ No ☐ Unk

   If Yes to any above, specify place: _____ When: _____

5. Attend or work in a day care center, preschool or babysitting group? ..... ☐ Yes ☐ No ☐ Unk

   If Yes, name of facility or group: _____ Telephone no.: _____

6. Work or reside in an institution for the developmentally disabled? ..... ☐ Yes ☐ No ☐ Unk

   If Yes, name of institution: _____ Telephone no.: _____

7. Have contact with diapered/incontinent child or adult? ..... ☐ Yes ☐ No ☐ Unk

   If Yes, describe situation: _____

8. Drink untreated/unchlorinated/unfiltered water? (well water, stream water, etc) ..... ☐ Yes ☐ No ☐ Unk

   If Yes, where and what type of water? _____ When: _____

9. Receive colonic procedure? (enemas, colonoscopy, etc) ..... ☐ Yes ☐ No ☐ Unk

   If Yes, name/location of facility that performed procedure: _____

   Telephone no. of location: _____ When procedure performed? _____

10. Consume unpasteurized milk or milk product? (raw milk, cheese, etc) ..... ☐ Yes ☐ No ☐ Unk

    If Yes, type of product: _____ Brand: _____

    Place of purchase? _____

EXPOSURE DETAILS Use progress notes for routine remarks. This space is only to expand on the questions above.

PHN signature	PHN Supervisor signature	Telephone number	Date
Area Medical Director's signature	For ACDC Only: Reviewer Signature	Date Closed	Report? ☐ Yes ☐ No