



Zika Virus Disease Case Investigation Form

Arboviral Diseases Branch



FOR ARBOVIRAL DISEASE BRANCH USE ONLY	
CDC R-number _____	ZIKVID: _____
CDC staff: _____	Date form completed: ____/____/____
Reporting Jurisdiction	
Jurisdiction (state/territory): _____	Agency: _____
Contact Name: _____	Contact Phone: _____
Contact Position: _____	Contact Email: _____
Demographic Information	
State ID number _____	Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months
Patient Initials: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
State of residence: _____	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, gestational week at illness onset: _____	
Travel History	
Dates of travel: _____	
Country(s) visited: _____	
Vaccination History	
Previously vaccinated for any of the following:	
<input type="checkbox"/> Yellow Fever	If yes, year of vaccination: _____
<input type="checkbox"/> Japanese Encephalitis	If yes, year of vaccination: _____
<input type="checkbox"/> Tickborne Encephalitis	If yes, year of vaccination: _____
Illness Information	
Illness onset date: ____/____/____	<input type="checkbox"/> Hospitalized <input type="checkbox"/> Died
Clinical syndrome: <input type="checkbox"/> Guillain-Barre syndrome /Acute flaccid paralysis <input type="checkbox"/> Microcephaly	
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: <input type="checkbox"/> Subjective fever <input type="checkbox"/> Measured fever (Maximum measured temperature: _____)	
Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: Type: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Other	
Pruritic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Distribution: _____	
Additional clinical symptoms	
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Headache
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Myalgia
	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Diarrhea
Specimen Information	
Specimen 1 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue
Specimen 2 collected: ____/____/____	Type: <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Tissue