Suspected Cutaneous Anthrax
Case Investigation Form

ID NUMBER:_____ INTERVIEWER:_____

AGENCY:_____

DATE OF INTERVIEW:____/____/____

PERSON INTERVIEWED: θPatient θOther

If other, Name of person _____

Telephone contact _____- _____- _____

Describe relationship _____

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____

SEX: θ Male θ Female DATE OF BIRTH: ____/____/____ AGE____

RACE: θ White θ Black θ Asian θ Other, specify _____ θUnknown

ETHNICITY: θ Hispanic θ Non-Hispanic θ Unknown

HOME TELEPHONE: ( ) _____-_____

WORK/OTHER TELEPHONE: ( ) _____-_____

HOME ADDRESS STREET: _____

CITY:_____ STATE:_____ZIP:_____

EMPLOYED: θ Yes θ No θ Unknown

OCCUPATION:_____

WORKPLACE/SCHOOL NAME:_____

WORK/SCHOOL ADDRESS: STREET: _____ CITY: _____

STATE:_____ZIP:_____

HOW MANY PEOPLE RESIDE IN THE SAME HOUSEHOLD? _____

LIST NAME(S), AGE(S), AND RELATIONSHIPS (use additional pages if necessary):

Name					
Age					
Relationship					

CLINICAL INFORMATION (as documented in admission history of medical record or from case/proxy interview)

CHIEF COMPLAINT: _____

DATE OF ILLNESS ONSET: ____/____/____

Briefly summarize History of Present Illness:

_____
_____
_____

SIGNS AND SYMPTOMS:

Onset date of lesion: ____/_____/_____

Symptoms	**Present?**
Cuts or abrasions	θYes θNo θUnknown Location(s) _____
Itchy papule (bump) on skin on skin	θYes θNo θUnknown Location(s) _____
Skin ulcer	θYes θNo θUnknown Location(s) _____
Fever	θYes θNo θUnknown If yes, maximum temperature _____ θ °F θ Antipyretics taken: θYes θNo θUr Date of onset:_____
Swelling/edema near site of lesion	θYes θNo θUnknown Location(s) _____
Lymph node swelling	θYes θNo θUnknown Location(s) _____
Chills	θYes θNo θUnknown
Headache	θYes θNo θUnknown
Malaise/fatigue	θYes θNo θUnknown
Back pain	θYes θNo θUnknown
Muscle tenderness/pain	θYes θNo θUnknown
Abdominal Pain	θYes θNo θUnknown
Diarrhea	θYes θNo θUnknown
Vomiting	θYes θNo θUnknown
Cough	θYes θNo θUnknown
Coryza	θYes θNo θUnknown
Lymphadenopathy	θYes θNo θUnknown
Other Symptoms/ abnormality	θYes θNo θUnknown Describe:

PAST MEDICAL HISTORY:

Dermatological Condition θYes θNo θUnknown

If yes, describe _____

Diabetes θYes θNo θUnknown
Malignancy θYes θNo θUnknown
Current Pregnancy θYes θNo θUnknown
HIV infection θYes θNo θUnknown
Other immunocompromising condition (eg. renal failure, cirrhosis, chronic steroid use)
θYes θNo θUnknown
If yes, specify disease or drug therapy: _____
Other underlying condition(s): _____
Prescription medications: _____
Antibiotics in the week prior to appearance of lesion? θYes θNo θUnknown
If yes list _____
Food or Drug Allergies θYes θNo θUnknown
If yes, describe _____

SOCIAL HISTORY:

Current alcohol abuse θYes θNo θUnknown
Past alcohol abuse θYes θNo θUnknown
Current injection drug use θYes θNo θUnknown
Past injection drug use θYes θNo θUnknown
Other illicit drug use θYes θNo θUnknown
If yes, specify _____

HOSPITAL INFORMATION

Hospitalized? θYes θNo θUnknown
Name of Hospital: _____
ICP name: _____ ICP telephone: ( ) _____-_____
Date of Admission _____/_____/_____ Date of Discharge _____/_____/_____
Name of attending physician: Last _____ First _____
Office telephone: ( ) _____-_____ Pager: ( ) _____-_____ Fax: ( ) _____-_____

MEDICAL RECORD ABSTRACTION:

MEDICAL RECORD NUMBER:_____

HOSPITAL NAME:_____

ROOM NUMBER:_____

ADMISSION DIAGNOSIS(ES):

1) _____
2) _____
3) _____

PHYSICAL EXAM :

Admission Vital Signs:

Temp____ (θoral / θrectal__ θ ^{o}F / θ ^{o}C) Heart Rate___

Respiratory Rate___ %Oxygen saturation _____

B/P___/___ Hypotension θYes θNo θUnknown

Level of consciousness: θAlert θDisoriented θLethargic θComatose

Skin exam: Lesion

Lesion Description (check all that apply):

θPapular θMacular θVesicular
θPetechial θBullous θErythematous
θPurpuric θPustular θScab
θUlcer θEschar
θDischarge (describe: _____)
θOther: _____

Lesion location (check off all areas of body where lesion is/was present):

θFace θChest/Abdomen θArms θLegs
θNeck θBack θHands θFeet
θMouth θPalms θSoles

Lesion size _____cm x _____cm

Skin exam: Other skin characteristics

Erythema θYes θNo θUnknown
If yes, where? _____
Edema θYes θNo θUnknown
If yes, where? _____
Induration θYes θNo θUnknown
If yes, where? _____

Other findings:

Lymphadenopathy θYes θNo θUnknown
If yes, specify size and location: _____

Other abnormal physical findings (describe):_____

DIAGNOSTIC STUDIES:

Test	**Results of tests done on admission (___/___/___)**	**Abnormal test result at any time (specify date mm/dd/yy)**
Hemoglobin (Hb)		(____/____/____)
Hematocrit (HCT)		(____/____/____)
Platelet (plt)		(____/____/____)

Total white blood cell (WBC)		(____/____/____)
WBC differential:		(____/____/____)
% granulocytes (PMNs)		(____/____/____)
% bands		(____/____/____)
% lymphocytes		(____/____/____)
Gram Stain of lesion	θ Gram positive rods θ Gram positive cocci θ Gram negative rods θ Gram negative cocci θ Pending θ Not done	θ Gram positive rods (____/____/____) θ Gram positive cocci (____/____/____) θ Gram negative rods (____/____/____) θ Gram negative cocci (____/____/____)
Bacterial culture from swab or biopsy of lesion	θ positive (specify_____) θ negative θ pending θ not done	θ positive (specify_____) θ negative θ pending θ not done (____/____/____)
Lesion biopsy	Specify:	Specify: (____/____/____)

Viral culture of lesion	θ positive (specify_____) θ negative θ pending θ not done	θ positive (specify_____) θ negative θ pending θ not done (____/____/____)
Bacterial Blood cultures	θ positive (specify_____) θ negative θ pending θ not done	θ positive (specify_____) θ negative θ pending θ not done (____/____/____)
Chest radiograph	θ normal θ unilateral, lobar/consolidation θ bilateral, lobar/consolidation θ interstitial infiltrates θ widened mediastinum θ pleural effusion θ other _____	θ normal θ unilateral, lobar/consolidation θ bilateral, lobar/consolidation θ interstitial infiltrates θ widened mediastinum θ pleural effusion θ other _____ (____/____/____)
Other pertinent study results		(____/____/____)

EPIDEMIOLOGIC LABORATORY TESTS

Nasal specimen culture	θ positive (specify_____) θ negative θ pending θ not done	θ positive (specify_____) θ negative θ pending θ not done (____/____/____)
Serology	θ positive (specify_____) θ negative θ pending θ not done	θ positive (specify_____) θ negative θ pending θ not done (____/____/____)

INFECTIOUS DISEASE CONSULT: θYes θNo θUnknown

Date:___/___/___

Name of physician: Last _____ First _____

Telephone or beeper number ( ) _____ - _____

HOSPITAL TREATMENT:

a) Antibiotics θYes θNo θUnknown

If yes, List antibiotics taken: _____

b) Antivirals θYes θNo θUnknown

If yes, Acyclovir (Zovirax) θYes θNo θUnknown

List other antivirals taken: _____

Did patient require intensive care? θYes θNo θUnknown

Length of stay in ICU, in days: _____

WORKING OR DISCHARGE DIAGNOSIS(ES):

1) _____
2) _____
3) _____

OUTCOME:

θRecovered/discharged

θDied

Still in hospital: a) improvingθ b) worseningθ

Comment: _____

ADDITIONAL COMMENTS:

Risk Exposure Questions

The following questions pertain to the 2 week period prior to the onset of your illness/symptoms, from ___/___/___ to ___/___/___:

Occupation (provide information for all jobs/ volunteer duties)

1. Work Address _____
2. Please briefly describe your job/ volunteer duties:_____

---

3. Usual work schedule (days and hours):
   _____

   3a. Did you work during days or hours different than those listed above anytime in the 2 weeks before your symptoms began? Yes No
   If yes, describe:_____

4. Where in the building do you work? Floor_____ Room # or location_____

5. Are there other locations in/around your building that you visited, for any reason, in the two weeks before your symptoms began? Yes No

   If yes,

	Floor/Room	Dates, Time, Duration (hours)	Accompanied by others (specify names, contact info)
Location 1			
Location 2			
Location 3			
Location 4			

6. Do you go into the mailroom at your workplace? Yes No
   If yes, on which days did you enter the mailroom during the two weeks before your symptoms began?

   Every day ___ from ___/___/___ to ___/___/___
   Dates:_____

7. Do you open mail at your workplace? Yes No
If yes, for whom? Self For others (specify, if known) _____

Where do you usually open your mail? _____

8. Did you, **or anyone else at your workplace**, open any piece of mail in the 2 weeks before your symptoms began that contained an unknown powder upon opening?
Yes No

8a. If yes, who opened the mail? Self Someone else (name(s)):
_____

8b. If someone else opened the letter/package, where were you in relation to the powder-containing mail at the time of opening? (indicate approximate distance):
_____

8c. Date and time of mail opening:_____
8d. Location where the letter/package was opened:_____

8e. Description of powder (color, consistency, odor, etc.): _____
_____

8f. Did the powder become aerosolized? Yes No

8g. Did you come in contact with any of the powder? Yes No
If yes, where? (hands, arms, face, clothing, etc.) _____
_____

8h. Describe any decontamination procedures that took place following exposure to powder: _____
_____
_____

8i. Approximately much time passed between exposure and decontamination?
_____

8j. List of all others potentially exposed to powder :

Name	Present at the time of letter/ package opening? Y/N	Location in relation to powder-containing letter at the time of opening (approx. distance)	If not present at the time of letter/package opening, give **location, time, and mode of exposure** (contact with hands, arms, face, inhalation, etc.) to powder	Contact info
			Location: Day/Time: Mode:	
			Location: Day/Time: Mode:	
			Location: Day/Time: Mode:	

			Location: Day/Time: Mode:	

8k. Description of letter/package: _____
Who was the package addressed to?:_____
Return address? _____
Where was it postmarked from? _____
Date of postmark? _____

8l. Was there a note accompanying the powder? Yes No
If yes, describe: _____
_____

8m. Was the police department and/or FBI notified? Yes No
If yes, do you have a case number and/or the name of the responding officers/agents? (specify)_____

9. Does your job involve contact with the public?
Yes No
If "Yes", specify_____

10. Does anyone else at your workplace have similar symptoms?
Yes No Unk
If "Yes", name and approximate date on onset (if known)_____

Knowledge of Other Ill Persons

4. Do you know of other people with similar symptoms? Y / N / Unk

(If Yes, please complete the following questions)

Name of ill person	Age	M/F	Address	Phone number(s)	Date of onset	Relation to you	Did they seek medical care? Where?	Were they diagnosed by a physician? Describe.

*Travel**

*Travel is defined as staying overnight (or longer) at somewhere other than the usual residence

8. Have you traveled anywhere in the last two weeks? Y / N / Unk

Dates of Travel: ____/____/____ to ____/____/____
Method of Transportation for Travel: _____
Where Did You Stay? _____
Purpose of Travel? _____

Did You Do Any Sightseeing on your trip? Yes □ No □
If yes, specify: _____
Did Anyone Travel With You? Yes □ No □
If yes, specify: _____
Are they ill with similar symptoms? Yes □ No □ Unk □

Information for Additional Trips during the past two weeks:
_____
_____

Public Functions/Venues (during 2 weeks prior to symptom onset)

Category	**Yes/No/ Unknown (Y/N/U)**	**Description of Activity**	**Location of Activity**	**Date of Activity**	**Time of Activity** (start, end)	**Anyone else ill? (Y/N/U)**
9. Sporting Event						
10. Performing Arts (ie Concert, Theater, Opera)						
11. Movie Theater						
12. Religious Gatherings						
13. Picnics						
14. Political Events (including Marches and Rallies)						
15. Meetings or Conferences (for work or personal interests)						
16. Family Planning Clinics						
17. Government Office Building						
18. Airports						
19. Shopping Malls						
20. Gym/Workout Facilities						
21. Casinos						
22. Beaches						
23. Parks						
24. Parties (including Raves, Prom, etc)						
25. Bars/Clubs						
26. Tourist Attractions (ie Sea World, Zoo, Disneyland)						
27. Museums						
28. Street Fairs, Swap Meets, Flea Markets						
29. Carnivals/Circus						
30. Campgrounds						

Transportation

Have you used the following types of transportation in the 2 weeks prior to onset?

31. Bus Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Bus Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Bus#_____)
Company Providing Transportation: _____ Destination:_____

32. Train/Metro Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Route Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Route #_____)
Company Providing Transportation: _____ Destination:_____

33. Airplane Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Flight Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Flight #_____)
Company Providing Transportation: _____ Destination:_____

34. Boat/Ferry Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Ferry Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Ferry #_____)
Company Providing Transportation: _____ Destination:_____

35. Van Pool/Shuttle Yes □ No □ Unk □
Frequency of this type of transportation: □ Daily □ Weekly □ Occasionally □ Rarely
Route Number: _____ Origin:_____
Any connections? Yes □ No □ (Specify: Location_____ Route #_____)
Company Providing Transporation: _____ Destination:_____

Food & Beverage

36. During the 2 weeks before your illness, did you eat at any of the following ***food establishments or private gatherings with food or beverages***? (If "yes", circle establishment(s); describe below)

Restaurant, fast-food or deli Y / N / Unk Grocery store or salad-bar Y / N / Unk Cafeteria at school, hospital, other Y / N / Unk Plane, boat, train, other Y / N / Unk
Concert, movie, other entertainment Y / N / Unk Gas station or 24-hr store Y / N / Unk Sporting event or snack bar Y / N / Unk Street-vended food Y / N / Unk Outdoor farmers market or swap meetY / N / Unk Beach, park or outdoor event Y / N / Unk Dinner party, barbecue or potluck Y / N / Unk Other food establishment Y / N / Unk Birthday party or other celebration Y / N / Unk Other private gathering Y / N / Unk

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____

Others also ill?: Y / N / Unk (explain):_____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

37. During the 2 weeks before your illness, did you consume any free ***food samples*** from……..?

Grocery store	Y / N / Unk
Race/competition	Y / N / Unk
Public gathering?	Y / N / Unk
Private gathering?	Y / N / Unk

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: _____ Location (Name and Address): _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: _____ Location (Name and Address):_____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

38. During the 2 weeks before your illness, did you consume any of the following ***products***?

Vitamins	Y / N / Unk	Specify (Include Brand Name):_____
Herbal remedies	Y / N / Unk	Specify (Include Brand Name):_____
Diet Aids	Y / N / Unk	Specify (Include Brand Name):_____
Nutritional Supplements	Y / N / Unk	Specify (Include Brand Name):_____
Other Ingested non-food	Y / N / Unk	Specify (Include Brand Name):_____

39. During the 2 weeks before your illness, did you consume any unpasteurized products (ie milk, cheese, fruit juices)? Y/N/Unk If yes, specify name of item:_____
Date/Time: _____ Location (Name and Address):_____
Others also ill?: Y / N / Unk (explain): _____

40. During the 2 weeks before your illness, did you purchase food from any internet grocers? Y/N/Unk
If yes, specify date / time of delivery:_____ Store/Site:_____
Items purchased:_____

41. During the 2 weeks before your illness, did you purchase any mail order food? Y/N/Unk
If yes, specify date/time of delivery:_____ Store purchased from:_____
Items purchased:_____

42. Please check the routine sources for drinking water (check all that apply):
Community or Municipal Well (shared) Well (private family)
Bottled water (Specify Brand:_____) Other (Specify:_____)

Aerosolized water

43. During the 2 weeks prior to illness, did you consume water from any of the following sources (check all that apply):
Wells Lakes Streams Springs Ponds Creeks Rivers
Sewage-contaminated water
Street-vended beverages (Prepared with water and sold by street vendors)
Ice prepared w/ unfiltered water (Prepared with water that is not from a municipal water supply or that is not bottled or boiled)
Unpasteurized milk
Other (Specify:_____)

If "YES" for any in question #43, provide date, time, location and type of water consumed:
Date/Time: _____ Location (Name and Address):_____
Type of water consumed: _____
Others also ill?: Y / N / Unk (explain):_____

44. During the 2 weeks prior to illness, did you engage in any of the following recreational activities (check all that apply):

Swimming in public pools (e.g., community, municipal, hotel, motel, club, etc)
Swimming in kiddie/wading pools
Swimming in sewage-contaminated water
Swimming in fresh water, lakes, ponds, creeks, rivers, springs, sea, ocean, bay (please circle)
Wave pools Water parks Waterslides Surfing
Rafting Boating Hot tubs (non-private) Whirlpools (non-private)
Jacuzzis (non-private) Other (Specify:_____)

If "YES" for any in question #44, provide date, time, location and type of activity:
Date/Time: _____ Location (Name and Address):_____
Type of water consumed: _____
Others also ill?: Y / N / Unk (explain):_____

If "YES" for any in question #44, provide date, time, location and type of activity:
Date/Time: _____ Location (Name and Address):_____
Type of water consumed: _____
Others also ill?: Y / N / Unk (explain):_____

45. During the 2 weeks prior to illness, were you exposed to aerosolized water from any of the following sources
46. (check all that apply):

Air conditioning at public places Respiratory devices* Vaporizers*
Humidifiers* Misters* Whirlpool spas* Hot tubs*
Spa baths* Creek and ponds Decorative fountains*
Other (please explain) _____
* Non-private (i.e., used at hospitals, spas, salons, etc.)

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:
Date/Time: _____ Location (Name and Address):_____

Explanation of aerosolized water: _____
Others also ill: Y / N / Unk (explain):_____

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:
Date/Time: _____ Location (Name and Address):_____
Explanation of aerosolized water: _____
Others also ill: Y / N / Unk (explain):_____

Recreation*

**Recreation is defined as non-work related activities*

46. In the past two weeks, did you participate in any outdoor activities? Y / N / Unk
(If "yes", list all and provide location)
_____
_____

47. Do you recall any insect or tick bites during these outdoor activities? Y / N / Unk
(If "yes", list all and provide location)
_____
_____

48. Did you participate in other indoor recreational activities (i.e. clubs, crafts, etc that do not occur in a private home)? Y / N / Unk
(List all and provide location)
_____
_____

Vectors

49. Do you recall any insect or tick bites in the last 2 weeks? Y / N / Unk
Date(s) of bite(s):_____ Bitten by □ Mosquito □ Tick □ Flea □ Fly □ Other:
Where were you when you were bitten? _____

50. Have you had any contact with wild or domestic animals, including pets? Y / N / Unk
Type of Animal: _____ Explain nature of contact:_____
Is / was the animal ill recently: Y / N / Unk Symptoms:_____
Date / Time of contact:_____ Location of contact:_____

51. To your knowledge, have you been exposed to rodents/rodent droppings in the last 2 weeks?
Y / N / Unk If yes, explain type of exposure:_____
Date/Time of exposure:_____
Location where exposure occurred:_____