



Human Infection with 2019 Novel Coronavirus Case Report Form

Fax completed form to:
DOH Disease Investigation Branch
(808) 586-4595

Patient first name: _____ Patient last name: _____ Date of birth (MM/DD/YYYY): ____/____/____
Address: _____ Phone: _____ Email: _____

Interviewer Information

Name of Interviewer: Last:	First:	Telephone:	Email:
Affiliation/Organization:			
Patient's Healthcare Provider (If different):		Telephone:	Email:

SARS-CoV-2 Testing (approved by FDA or other designated authority)

Test	Pos	Neg	Indet.	Pend.	Not Done	Specimen collection date
Molecular amplification test (RT PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Serologic test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

Symptoms present during course of illness:
 Symptomatic Asymptomatic Unknown
If case was symptomatic:
 Onset date (MM/DD/YYYY): ____/____/____
 Unknown symptom onset date

Hospitalization, ICU, and Death Information

Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date _____ discharge date _____ ____/____/____ (MM/DD/YYYY) ____/____/____	Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, admission date _____ discharge date _____ ____/____/____ (MM/DD/YYYY) ____/____/____
Did the patient die as a result of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of death (MM/DD/YYYY): ____/____/____ <input type="checkbox"/> Unknown date	

Case Demographics

Date of birth (MM/DD/YYYY): ____/____/____ Age: _____ Age units (yr/mo/day): _____ State of residence: _____ County of residence: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Unknown If female, currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander, specify: _____ <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian, specify: _____ <input type="checkbox"/> Black <input type="checkbox"/> Other, specify: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown Primary Language: _____ Is a translator/interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify which language: _____
What is the patient's occupation? Industry: _____ Occupation: _____		

Healthcare Worker Information

Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, what is their occupation (type of job)? <input type="checkbox"/> Physician <input type="checkbox"/> Respiratory therapist <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Nurse <input type="checkbox"/> Environmental services <input type="checkbox"/> Unknown	If yes, what is their job setting? <input type="checkbox"/> Hospital <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Unknown

Exposure Information

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply): <input type="checkbox"/> Contact with a known COVID-19 case (probable or confirmed) <i>If the patient had contact with a known COVID-19 case, what type of contact?</i> <input type="checkbox"/> Household contact <input type="checkbox"/> Community-associated contact <input type="checkbox"/> Healthcare-associated contact (patient, visitor, or healthcare worker) <input type="checkbox"/> Travel <input type="checkbox"/> Interisland. Specify island(s): _____ <input type="checkbox"/> Mainland U.S. travel. Specify state(s): _____ <input type="checkbox"/> International travel. Specify country(s): _____ <input type="checkbox"/> Airport/Airplane <input type="checkbox"/> Cruise ship or vessel travel as passenger or crew member. Specify name of ship: _____ <input type="checkbox"/> Congregate settings <input type="checkbox"/> Workplace <input type="checkbox"/> Adult congregate living facility (nursing, assisted living, or long-term care facility) <input type="checkbox"/> School/university/childcare center <input type="checkbox"/> Correctional facility <input type="checkbox"/> Community event/mass gathering <input type="checkbox"/> Animal with confirmed or suspected COVID-19. Specify animal: _____ <input type="checkbox"/> Other exposures, specify: _____	Which would best describe where the patient was staying at the time of illness onset? <input type="checkbox"/> Traditional housing <input type="checkbox"/> House/single family home <input type="checkbox"/> Apartment <input type="checkbox"/> Healthcare/assisted Living <input type="checkbox"/> Long term care facility <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Acute care inpatient facility <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Other congregate/non-traditional housing <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Hotel/motel <input type="checkbox"/> Outside, in a car, or other location not meant for human habitation <input type="checkbox"/> Correctional facility <input type="checkbox"/> Mobile home <input type="checkbox"/> Group home <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
Is this case part of an outbreak? <input type="checkbox"/> Yes, specify outbreak name: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	



Human Infection with 2019 Novel Coronavirus Case Report Form

Fax completed form to:
DOH Disease Investigation Branch
(808) 586-4595

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/____/____

Clinical course, symptoms, past medical history, and social history

Collected from (check all that apply): Patient interview Medical record review Other, specify: _____

Did the patient experience any of the following complications due to their illness?

Did the patient develop pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient have an abnormal EKG? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no EKG done
Did the patient have acute respiratory distress syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient receive mechanical ventilation (MV)/intubation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, total days with MV (days) _____
Did the patient have an abnormal chest X-ray? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A, no chest X-ray done	Did the patient receive ECMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did the patient have another diagnosis/etiology for their illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

If symptomatic, which of the following did the patient experience during their illness?

Fever ≥100.4°F (38°C)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
New olfactory and taste disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea (≥3 loose stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other, specify: _____, _____,	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		

Did the patient's symptoms resolve? Yes, date of symptom resolution (MM/DD/YYYY): ____/____/____
 Symptoms resolved, unknown date
 No, still symptomatic
 Unknown if symptoms resolved

Did they have any underlying medical conditions and/or risk behaviors? Yes No Unknown

Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) If yes, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Severe obesity (BMI ≥40)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Psychological/psychiatric condition If yes, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Chronic Renal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other chronic diseases If yes, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Chronic Lung disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Immunosuppressive condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other underlying condition or risk behavior, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Autoimmune condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		

History of substance use

Tobacco smoking	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never
Vaping/E-cig	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never
Alcohol use disorder	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never
Other substances Specify: _____	<input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never

Additional Comments or Notes