v20200824

Human Infection with 2019 Novel Coronavirus

Short Form

Maven ID:__________________

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

Address:______________________________ Phone: (________) ________-__________ Email: ______________________

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? ☐ Yes ☐ No ☐ Unknown If yes, admission date ___/___/_____ (MM/DD/YYYY) discharge date ___/___/______	Was the patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown If yes, admission date ___/___/_____ (MM/DD/YYYY) discharge date ___/___/______
Did the patient die as a result of this illness? ☐ Yes ☐ No ☐ Unknown If yes, date of death (MM/DD/YYYY):____/_____/_____ ☐ Unknown date	

Case Demographics

Sex: ☐ Male ☐ Other ☐ Female ☐ Unknown If female, currently pregnant? ☐ Yes ☐ No ☐ Unknown What is the patient's occupation? Industry: ______________________ Occupation: ______________________	Race (check all that apply): ☐ White ☐ Native Hawaiian ☐ Pacific Islander, specify: ____________ ☐ Japanese ☐ Filipino ☐ Chinese ☐ Other Asian, specify: ____________ ☐ Black ☐ Other, specify: ____________	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown Primary Language: ______________ Is a translator/interpreter required? ☐ Yes ☐ No ☐ Unknown *If yes, specify which language*: ______________

Healthcare Worker Information

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

Exposure Information

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

Past Medical History

Did they have any underlying medical conditions and/or risk behaviors? ☐ Yes ☐ No ☐ Unknown			
Severe obesity (BMI ≥40)	☐ Yes ☐ No ☐ Unknown	Chronic lung disease (Severe asthma/emphysema/COPD)	☐ Yes ☐ No ☐ Unknown
Chronic renal disease	☐ Yes ☐ No ☐ Unknown	Immunosuppressive condition	☐ Yes ☐ No ☐ Unknown
Current smoker	☐ Yes ☐ No ☐ Unknown	Former smoker	☐ Yes ☐ No ☐ Unknown