Patient First Name:_____________ Patient Last Name:_______________ Phone: _______________
DOB:(MM/DD/YYYY) ________Address: ______________________________ City: _______________
Reporting Health Dept:________________________________ Email: _______________________________

Interviewer Information:

Name of Interviewer: Last:_______________________________ First:_______________________________
Email:____________________________________ Phone: ___________________

Basic Information

Date: _________ Monitoring Day: _____

<table>
<tr>
<td>Demographics
Race:__________________ Language:____________________
Ethnicity:_______________ Other-specify: ________________
Disability:_______________
Pregnant: ______________</td>
<td rowspan="2">Was patient hospitalized?
☐ Yes ☐ No ☐ Unknown
If yes, admission date:
__________ (MM/DD/YYYY)
If yes, discharge date:
__________ (MM/DD/YYYY)
Was patient admitted to an intensive care unit? (ICU)
☐ Yes ☐ No ☐ Unknown

Symptom resolution?
__________ (MM/DD/YYYY)
☐ Still symptomatic
☐ Unknown symptom status
☐ Symptoms resolved, unknown date</td>
</tr>
<tr>
<td>☐ PUM (Close Contact) ☐ Unknown
☐ Suspect Case
☐ Presumptive case
☐ Laboratory-confirmed case Symptoms present during course of illness?
☐ Symptomatic Symptom onset date?
☐ Asymptomatic __________ (MM/DD/YYYY)</td>
</tr>
<tr>
<td colspan="2">Is the patient a health care worker in the United states? ☐ Yes ☐ No ☐ Unknown
History of being in a healthcare facility? ☐ Yes ☐ No ☐ Unknown
In the 14 days prior to illness onset, did patient have any of the following? (check all that apply):
☐ Travel outside of US? ☐ Community contact with confirmed case ☐ Other
Specify:_______________ ☐ Healthcare contact with confirmed case Specify _________________
☐ Household contact with confirmed case? ☐ Unknown</td>
</tr>
<tr>
<td colspan="2">Under what process was the case first identified? (check all that apply):
☐ Clinical evaluation ☐ Contact tracing of case patient
☐ Routine surveillance ☐ OHA Notification ☐ Unknown
☐ Other, specify:_____________________________________</td>
</tr>
<tr>
<td colspan="2">Is Case/Contact Employed? _____ Employer_____________________ Employer Phone:______________</td>
</tr>
</table>

Symptoms ever, past medical history

Collected from (check all that apply): □ Patient interview □ Medical record review No Symptoms

Symptom			
Fever >100.4F (38C) Ever	□ Yes	□ No	□ Unknown
Subjective fever (felt feverish) Ever	□ Yes	□ No	□ Unknown
Chills Ever	□ Yes	□ No	□ Unknown
Muscle aches (myalgia) Ever	□ Yes	□ No	□ Unknown
Runny nose (rhinorrhea) Ever	□ Yes	□ No	□ Unknown
Sore throat Ever	□ Yes	□ No	□ Unknown
Cough (new onset or worsening of chronic cough) Ever	□ Yes	□ No	□ Unknown
Shortness of breath (dyspnea) Ever	□ Yes	□ No	□ Unknown
Nausea or vomiting Ever	□ Yes	□ No	□ Unknown
Headache Ever	□ Yes	□ No	□ Unknown
Abdominal pain Ever	□ Yes	□ No	□ Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period) Ever	□ Yes	□ No	□ Unknown
New loss of taste or smell? Ever	□ Yes	□ No	□ Unknown

Condition			
Pre-existing medical conditions?	□ Yes	□ No	□ Unknown
Chronic Lung Disease (asthma/emphysema/COPD)	□ Yes	□ No	□ Unknown
Diabetes Mellitus	□ Yes	□ No	□ Unknown
Cardiovascular disease	□ Yes	□ No	□ Unknown
Chronic Renal disease	□ Yes	□ No	□ Unknown
Chronic Liver disease	□ Yes	□ No	□ Unknown
Immunocompromised Condition	□ Yes	□ No	□ Unknown
Neurologic/neurodevelopmental/intellectual	□ Yes	□ No	□ Unknown
disability	□ Yes	□ No	□ Unknown
Other chronic diseases (If YES, specify)	□ Yes	□ No	□ Unknown
If female, currently pregnant	□ Yes	□ No	□ Unknown
Current smoker	□ Yes	□ No	□ Unknown
Former smoker	□ Yes	□ No	□ Unknown
Specify all YES:____			

Daily Notes:
Day 1
Day 2
Day 3
Day 4
Day 5
Day 6
Day 7
Day 8
Day 9
Day 10