

Form B: Q Fever: Information for Diagnostic Specimens

To accompany all specimens submitted to VRZB/CDC for routine diagnostic testing for *Coxiella burnetii*.
Call 404-639-1075 if you have questions on how to fill out this form.

Patient Name: _____

Patient DOB ____/____/____

Patient State of Residence: _____

Current Patient Occupation: (include past occupation for chronic infection) _____

CLINICAL HISTORY

Type of Q fever: Acute Chronic

Date of Onset of Symptoms ____/____/____

First reported symptom _____

Clinical Signs and syndromes (check all that apply)

- fever (_____)
- headache
- malaise
- myalgia
- retrobulbar pain
- cough
- lymphadenopathy
- rash
- splenomegaly
- hepatomegaly
- pneumonia
- hepatitis
- endocarditis
- myocarditis
- other (specify) _____

Laboratory Values

ALT and/or AST level _____

WBC _____

Specify any severe or unusual manifestations

- pneumonia/ ARDS
- renal failure
- neurologic impairment
- coagulopathies
- meningitis/encephalitis
- other _____

Was the patient hospitalized because of this illness? yes no unk

If Yes, Date of hospital admittance: ____/____/____

Date of hospital discharge ____/____/____

Was this a fatal infection? yes no unk

Treatment: Date started: ____/____/____

- Tetracycline/Doxycycline yes no unk
- Chloramphenicol yes no unk
- Fluoroquinolone yes no unk
- Other (specify) _____ yes no unk

EXPOSURE HISTORY

In the month prior to illness onset, did the patient report contact with any of the following animals:

sheep goats cattle pigs cats dogs rats/mice wild animals (specify _____)

other (specify _____)

Approximate date of contact: ____/____/____

Was the contact with an animal that was giving or had recently given birth? yes no unk

In the month prior to illness, did the patient consume unpasteurized dairy products? yes no unk

Approximate date of consumption: ____/____/____

Did the patient have a known tick bite or exposure in the month prior to illness? yes no unk

Specify type of exposure: bite observed tick exposure to habitat

Approximate date: ____/____/____

TRAVEL HISTORY

Did the patient travel during the month prior to illness onset? yes no unk

US City/state(s) visited _____ Dates: _____

Foreign Country(s): _____ Dates: _____

Did the patient travel as part of a larger group? yes no unk

Do any other members of the group have a similar illness? yes no unk

CDC Use Only: DASH # _____

Accession # _____

Patient # _____