



Communicable Disease Control Unit, San Francisco Department of Public Health

West Nile Case History Form

This case history form is required for testing (specimens will not be tested without this form.)

Specimens submitted via public health laboratories must meet the criteria for West Nile virus testing. (See "West Nile Virus Laboratory Testing Guidelines")

Investigator # _____ Date of Report to San Francisco Department of Public Health: ___/___/___

Patient Information:

Last name _____ First name _____ Middle Name _____ DOB ___/___/___

Age: _____ Street Address: _____ City: _____ State: _____ Zip Code _____

Home Phone: _____ Work : _____ Cell: _____

Sex: Male Female Unk Ethnicity: Hispanic Non-Hispanic Unk

Race: White Black Native American Asian/Pacific Islander Other Unk

Job/Type of Work: _____

City: _____

Physician Information: Mandatory

Name: _____ Facility: _____ Telephone: _____

Pager: _____ Fax: _____

Email: _____

Medical Record # _____

Symptom Onset : ___/___/___ Last date: ___/___/___

Hospitalized ER Outpatient /Not admitted

Date of admit: ___/___/___

Do the following apply anytime during current illness:

In ICU No Yes Unk

Fever ≥38° (100.4) No Yes Unk

Highest Temperature, if recorded _____

Headache No Yes Unk

Rash No Yes Unk

Stiff neck No Yes Unk

Muscle Weakness No Yes Unk

Altered Consciousness No Yes Unk

Encephalitis No Yes Unk

Aseptic Meningitis No Yes Unk

Flaccid Paralysis No Yes Unk

Asymmetrical No Yes Unk

CSF results

CBC results

Date: _____

Date: _____

RBC: _____

WBC: _____

WBC: _____

%Diff: _____

%Diff: _____

HCT: _____

Protein: _____

Plt: _____

Glucose _____

Other Information (MRI/CT,LFTs etc.)

Exposures within 4 wks of onset(specify location, dates):

Mosquito bites/exposure: No Yes Unk

Outdoor activity (hiking, gardening, etc.) No Yes Unk

Received Blood Transfusion or organ transplant: No Yes

If yes, Date: _____ Type: _____

Exact location: _____

Travel within 4 wks of onset (specify location, dates):

Within California (out of SF) No Yes Unk

Within the United States? No Yes Unk

Outside of the United States? No Yes Unk

Ever traveled outside the US? No Yes Unk

Other pertinent information:

Immunocompromised patient: No Yes Unk

Yellow fever vaccination: No Yes Unk

Date: _____

Military service: No Yes Unk

Dates: _____

Current Pregnancy No Yes Unk

Week of gestation: _____

Breast Feeding? No Yes Unk

Donated Blood within 4 wks of onset: No Yes Unk

If yes, Date: _____ Exact location: _____

Significant Past History (medical, social, family) and other exposures: _____

Clinical Outcome:

Survived Died, Date of death ___/___/___ Unk

For CDCU Use ONLY:

1. Meets WNV criteria? Yes No 2. Specimen submitted? Yes No 3. If yes, date submitted? ___/___/___

To report by phone or for questions regarding testing or specimen submission, call the CD Control Unit, at 415-554-2830 (24 hours/7 days a week). Fax this form to (415) 554-2848

Send Specimens to: San Francisco Public Health Laboratory, 101 Grove Street, Room 412, SF, CA 94102