CYCLOSPORIASIS CASE REPORT FORM
STATE OF FLORIDA
DEPARTMENT OF HEALTH

CASE NO. ____________

CONTROL NO. ____________

PERSONAL DATA

Name (Last) (First) (MI) ____________

Birthdate: ___MO ___DA___YR

Sex: 1. ☐ Male 2. ☐ Female

Address: Zip Code: ____________

County: ____________

Occupation: ____________

Race: Hispanic 1☐Yes 2 ☐No 9 ☐Unknown
1☐American Indian/Alaskan Native 2☐ Pacific Islander 3☐ Black 4☐White 8☐Other 9☐Unknown

SYMPTOMS

Onset (Date of first symptom): ______ MO ______ DA ______ YR

Did person have:	Yes	No	Unk
Diarrhea	☐	☐	☐

If yes:

- For how many days? ____________
- Maximum number of episodes of diarrhea in a day: ____________
- Blood in stools? ☐ ☐ ☐

Did person have:	Yes	No	Unk
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Loss of appetite	☐	☐	☐
Stomach cramps	☐	☐	☐
Gas or bloating	☐	☐	☐
Weight Loss	☐	☐	☐
Fatigue (tiredness)	☐	☐	☐
Chills	☐	☐	☐
Headaches	☐	☐	☐
Body aches	☐	☐	☐
Constipation	☐	☐	☐
Fever	☐	☐	☐

Highest temp_____ F

Other ____________

TREATMENT

Admitted to Hospital? 1☐ Yes 2☐ No 9 ☐ Unk

If yes, hospital name: ____________

Physician/Clinic name: ____________

Telephone Number ( ) ____________

Date of Diagnosis: (positive stool specimen) ____ MO____DA____YR

Laboratory where diagnosed: ____________

Telephone Number: ( ) ____________

EXPOSURE DATA

	Yes	No	Unk
Foreign travel within 2 months before illness started?	1☐	2☐	9☐

If yes, where?
1 ☐ South/Central America/Mexico
2 ☐ Africa
3 ☐ Carribean
4 ☐ Middle East
5 ☐ Asia/South Pacific
6 ☐ Austrailia/New Zealand
7 ☐ Europe
8 ☐ Other

When? ____ MO____DA____YR to ____ MO____DA____YR

Travel to another state within 2 weeks before illness started?	☐	☐	☐

If yes, where? ____________ When? __ MO__ DA __ YR to __ MO__ DA __YR

Is this case outbreak related?	☐	☐	☐

Comments: ____________

Investigator: ____________

Interview Date: ____________

1/97