LISTERIOSIS CASE ABSTRACTION FORM

DEMOGRAPHIC INFORMATION

OUTCOME: ____________________

Last Name: ________________________________ First Name: ____________________________ Sex: ______

Street Address: __________________________________ City: ______________________ Zip Code: _________

Health District Name: ______________________ Health District Number: _________ SPA Number: ________

DOB: ___________ AGE: _____ RACE: ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ Other ☐ Unknown

Hospital Name: ____

TYPES OF CASES: ☐Sepsis ☐Meningitis ☐Gastrointestinal ☐ Perinatal ☐ Nonperinatal

RISK FACTORS

- ☐ Alcoholism
- ☐ Gastrointestinal Disease
- ☐ Diabetic
- ☐ Organ Transplant
- ☐ Asthma
- ☐ Kidney Disease/Dialysis
- ☐ Chronic Lung Disease
- ☐ Liver Disease
- ☐ Cancer (non-hematological)
- ☐ Hematological (blood) Cancer – lymphomas, leukemia
- ☐ Autoimmune Disorder (hypothyroidism, rheumatoid arthritis, lupus, multiple sclerosis, etc.)
  Specify disorder:
  ____
- ☐ Iron overload or hemochromatosis
- ☐ Use of iron supplements
  Specify type and amount:
  ____
- ☐ Blood disorder (ex. chronic anemia, sickle cell disease)
- ☐ Received recent blood transfusion
  Specify: type (whole blood, platelets, plasma), dates, location and/or blood bank:
  ____
- ☐ Blood donation in past year
  Specify: type (whole blood, platelets, plasma), dates, location and/or blood bank:
  ____

- ☐ Currently Pregnant
  If yes…Gestational age at admission (wk) _____
- ☐ Multiple gestations for current pregnancy
  If yes, # ______
  Gravida (# of pregnancies incl. current one) ____
  Parity (# of live births) ____
- ☐ Recent Post-partum (within past two months).
  If yes… Date pregnancy ended ____________
- ☐ HIV Positive ☐ AIDS ☐ Injection Drug Use
- ☐ Age ≥ 65
- ☐ Travel outside U.S. in year prior to illness (incl. MX)?
  If yes, where and what dates?
  ____
  ____
- ☐ Other risk factors (hypertension, heart disease)
  ____
  ____

Risk summary (ranked strongest risk factor first)

Risk 1:

Risk 2:

Risk 3:

Risk 4:

Risk 5:

CLINICAL INFORMATION

Date of Admission: _________________ Date Onset of Symptoms: _________________

Admission Diagnosis: ____

Medicines on Admission: ____

____

☐ Antibiotics in past 6 months Please give names/dates: ____

☐ Chemotherapy in past year (“Anticancer drugs”)

☐ Radiation therapy in past year

☐ Antacids in past 3 months (Ranitidine, Tagamet, Maalox, Tums): ____________________________________

☐ Prior gastric surgery

☐ Steroids in past 6 months

☐ Folk medicine, herbal remedies or supplements (excluding vitamins) in past 6 months

☐ Other immunosuppressive drugs in past 6 months (immure, azothiaprin): ______________________________

SYMPTOM PROFILE

Before admission, was the patient ill with any of the following? ☐ Unknown ☐ Asymptomatic

	Onset Date	
☐ Fever	__________	Highest temperature __________
☐ Abdominal pain	__________	
☐ Diarrhea	__________	
☐ Nausea	__________	
☐ Vomiting	__________	
☐ Dizziness	__________	
☐ Stiff neck	__________	
☐ Confusion/Altered mental status	__________	
☐ Backache	__________	
☐ Sore throat	__________	
☐ Cough	__________	
☐ Shortness of breath	__________	
☐ Chills	__________	
☐ Headache	__________	
☐ Nasal congestion/Runny nose	__________	
☐ Dysuria (burning urination)	__________	
☐ Myalgia (muscle aches)	__________	
☐ Joint aches	__________	
☐ Rash	__________	
☐ Vaginal bleeding	__________	
☐ Vaginal discharge	__________	
☐ Other	__________	

TREATMENT DATA

Antibiotic #1: ____________________________
Date Started: ________ Date Ended:_________
Dosage: ________ No. times per day: _____
Total dosage per day: __________

Antibiotic #2: ____________________________
Date Started: ________ Date Ended:________
Dosage: ________ No. times per day: _____
Total dosage per day: ___________

Antibiotic #3: ____________________________
Date Started: ________ Date Ended:________
Dosage: ________ No. times per day: ____
Total dosage per day: ___________

LABORATORY DATA (nonperi or maternal)

Site of culture + ______________ Date: _________

Site of culture + ______________ Date: _________

OBSTETRIC HISTORY (perinatal cases only)

Type of Case:

☐ Intrapartum
☐ Early-onset post-partum (# days after birth: _______)
☐ Late-onset post-partum (# days after birth: _______)

Baby name: _________________________________

Type of Delivery:

☐ Uncomplicated vaginal
☐ Caesarian section
☐ VBAC

Gestational age ____________ DOB _____________
Birth weight _______________ Sex: _____________
Date of first positive culture: _____________________
Culture site 1: __________ Culture site 2: __________

Baby Birth Outcome:

☐ Alive & well
☐ Alive & sick
☐ Stillborn/abortion
☐ Died after birth
☐ Unknown, continuing pregnancy (call after expected birth date)

Was the mother educated about listeriosis by her health care provider prior to her illness? ☐Y ☐N

PERINATAL TREATMENT DATA

Antibiotic #1: ____________________________
Date Started: ________ Date Ended:_________
Dosage: ________ No. times per day: _____
Total dosage per day: __________

Antibiotic #2: ____________________________
Date Started: ________ Date Ended:________
Dosage: ________ No. times per day: _____
Total dosage per day: ___________

Antibiotic #3: ____________________________
Date Started: ________ Date Ended:________
Dosage: ________ No. times per day: ____
Total dosage per day: ___________

FOOD HISTORY

☐ Raw milk	☐ Raw beef	☐ Raw cow tongue	☐ Cold cuts/deli meats
☐ Any raw milk-product	☐ Raw pork	☐ Raw poultry	☐ Turkey
☐ Soft cheese	☐ Raw eggs	☐ Raw fish/seafood	☐ Raw fruits
☐ Mexican style fresh cheese Specify type: _________________		☐ Other cheese Specify type: ______________	☐ Raw vegetables

Provide details below (product name, manufacturer, purchase dates, name and location where purchased, dates first eaten):