

**COCCIDIOIDOMYCOSIS (VALLEY FEVER)
CASE HISTORY REPORT**



CENSUS TRACT: _____ VCMR ID: _____

Patient name-last		first	middle initial	Date of Birth	Age	Sex
Address- number, street			City	State	ZIP Code	
Telephone number		Work ()		Cell ()		
Home ()						
Race (check one)				Ethnicity (check one)		
<input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____				<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, please check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____						
Occupation			City			
Was the patient incarcerated 1 month prior to onset of disease? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify where and when. _____						

PRESENT ILLNESS

Onset date	Diagnosis date	Attending or consulting physician	Fax number ()	Telephone number ()	
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date	Discharge date	Facility/Hospital Name		
If female: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Medical record number	Outcome <input type="checkbox"/> Recovered <input type="checkbox"/> Fatal Date of Death: _____		
Check any symptoms that apply: <input type="checkbox"/> Influenza-like illness (e.g. fever, chest pain, cough, muscle pain, headache, etc.) <input type="checkbox"/> Pneumonia/pulmonary lesion <input type="checkbox"/> Rash: Erythema nodosum/Erythema multiforme <input type="checkbox"/> Bone, joint, or skin involvement <input type="checkbox"/> Meningitis <input type="checkbox"/> Disseminated disease <input type="checkbox"/> Other: Specify _____		Check all significant past medical history that apply: <input type="checkbox"/> Diabetes If checked, What type?: <input type="checkbox"/> Type I OR <input type="checkbox"/> Type II <input type="checkbox"/> Asthma <input type="checkbox"/> Other chronic lung disease If checked, Specify _____ <input type="checkbox"/> Chronic dialysis <input type="checkbox"/> Organ transplant <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Injection drug use <input type="checkbox"/> Other If checked, Specify _____			
Was the patient previously diagnosed with coccidioidomycosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, when and where? _____					

DIAGNOSTIC TESTS (List all tests performed and attach laboratory results.)

Type of Test	Source of Specimen	Date Collected	Results	Name and Address of Laboratory
Serological				
Culture				
Tissue specimen (Biopsy or autopsy?)				
Skin Test				
Other (Specify)				

REMARKS

CONTACT INFORMATION

Investigator's name (print)	Investigator's signature	Date	Telephone number ()
Agency name/Health District	Supervisor's signature (if applicable)	Medical Director's signature (if applicable)	