

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name <input style="width: 95%;" type="text"/>		Social Security Number <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/>		Ethnicity (✓ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
First Name/Middle Name (or initial) <input style="width: 95%;" type="text"/>		Birth Date Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>		Age <input style="width: 25%;" type="text"/>	
Address: Number, Street <input style="width: 95%;" type="text"/>				Apt./Unit Number <input style="width: 50%;" type="text"/>	
City/Town <input style="width: 95%;" type="text"/>		State <input style="width: 25%;" type="text"/>	ZIP Code <input style="width: 50%;" type="text"/>		
Area Code <input style="width: 25%;" type="text"/>	Home Telephone <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	Estimated Delivery Date Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>	
Area Code <input style="width: 25%;" type="text"/>	Work Telephone <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/>	Patient's Occupation/Setting <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other _____		Race (✓ one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (✓ one): <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White: _____ <input type="checkbox"/> Other: _____	

DATE OF ONSET Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>	Reporting Health Care Provider <input style="width: 95%;" type="text"/>	REPORT TO
DATE DIAGNOSED Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>	Reporting Health Care Facility <input style="width: 95%;" type="text"/>	
DATE OF DEATH Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>	Address <input style="width: 95%;" type="text"/>	
	City _____ State _____ ZIP Code _____	
	Telephone Number () _____ Fax () _____	
	Submitted by _____ Date Submitted (Month/Day/Year) <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>	

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STD)	VIRAL HEPATITIS																																																							
Syphilis <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Secondary <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Congenital <input type="checkbox"/> Latent (unknown duration) <input type="checkbox"/> Neurosyphilis	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th>Pend</th> <th>Not Done</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Hep A anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep B anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Acute anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chronic anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep C anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Acute PCR-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chronic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep D (Delta) anti-Delta</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Pos	Neg	Pend	Not Done	<input type="checkbox"/> Hep A anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hep B anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acute anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hep C anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acute PCR-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hep D (Delta) anti-Delta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Syphilis Test Results <input type="checkbox"/> RPR Titer: _____ <input type="checkbox"/> VDRL Titer: _____ <input type="checkbox"/> FTA/MHA: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other: _____																																																								
Gonorrhea <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____	Chlamydia <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____																																																							
STD TREATMENT INFORMATION <input type="checkbox"/> Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated: Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/>	<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____																																																							
Suspected Exposure Type <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Other needle exposure <input type="checkbox"/> Sexual contact <input type="checkbox"/> Household contact <input type="checkbox"/> Child care <input type="checkbox"/> Other: _____																																																								

TUBERCULOSIS (TB) Status	Mantoux TB Skin Test	Bacteriology	TB TREATMENT INFORMATION
<input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Converter <input type="checkbox"/> Reactor	Date Performed: Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> Results: _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done	Date Specimen Collected: Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> Source _____ Smear: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done BCG Vaccine Given? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, at what age/year? _____ Other test(s) _____	<input type="checkbox"/> Current Treatment <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/> EMB <input type="checkbox"/> Other: _____ Date Treatment Initiated: Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> <input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____
Site(s) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both	Chest X-Ray Date Performed: Month Day Year <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> / <input style="width: 25%;" type="text"/> <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory		

REMARKS

