

# CONFIDENTIAL MORBIDITY REPORT

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

**DISEASE BEING REPORTED:** \_\_\_\_\_

<b>Patient's Last Name</b> _____		<b>Social Security Number</b> ____-____-____		<b>Ethnicity (✓ one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
<b>First Name/Middle Name (or initial)</b> _____		<b>Birth Date</b> Month Day Year ____/____/____		<b>Age</b> ____	
<b>Address: Number, Street</b> _____				<b>Apt./Unit Number</b> _____	
<b>City/Town</b> _____		<b>State</b> ____	<b>ZIP Code</b> ____-____-____		
<b>Area Code</b> ____	<b>Home Telephone</b> ____-____-____		<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Pregnant?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<b>Estimated Delivery Date</b> Month Day Year ____/____/____
<b>Area Code</b> ____	<b>Work Telephone</b> ____-____-____		<b>Patient's Occupation/Setting</b> <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 _____		
<b>Race (✓ one)</b> <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: _____					

<b>DATE OF ONSET</b> Month Day Year ____/____/____		<b>Reporting Health Care Provider</b> _____		<b>REPORT TO</b>	
<b>DATE DIAGNOSED</b> Month Day Year ____/____/____		<b>Reporting Health Care Facility</b> _____			
<b>DATE OF DEATH</b> Month Day Year ____/____/____		<b>Address</b> _____			
		<b>City</b> _____ <b>State</b> ____ <b>ZIP Code</b> ____-____-____			
		<b>Telephone Number</b> ( ) _____	<b>Fax</b> ( ) _____		
		<b>Submitted by</b> _____	<b>Date Submitted</b> (Month/Day/Year) ____/____/____		

(Obtain additional forms from your local health department.)

<b>SEXUALLY TRANSMITTED DISEASES (STD)</b>			<b>VIRAL HEPATITIS</b>																																																										
<b>Syphilis</b> <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			<b>Syphilis Test Results</b> <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: _____		<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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<b>Gonorrhea</b> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____			<b>Chlamydia</b> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____		<b>PID (Unknown Etiology)</b> <input type="checkbox"/> Chancroid <input type="checkbox"/> Non-Gonococcal Urethritis																																																								
<b>STD TREATMENT INFORMATION</b> <input type="checkbox"/> Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated: ____/____/____			<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: _____		<b>Suspected Exposure Type</b> <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: _____																																																								

<b>TUBERCULOSIS (TB) Status</b> <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		<b>Mantoux TB Skin Test</b> Date Performed: ____/____/____ Results: _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done		<b>Bacteriology</b> Date Specimen Collected: ____/____/____ 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): _____		<b>TB TREATMENT INFORMATION</b> <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: ____/____/____ <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: _____	
<b>Site(s)</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both		<b>Chest X-Ray</b> Date Performed: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory					

**REMARKS**  
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