

BLASTOMYCOSIS CASE REPORT FORM

Please fax completed form to Dr. Ireland at 651-201-5743

A. DEMOGRAPHIC INFORMATION

Patient Name: _____
Parent Name (if minor): _____
Address: _____
City: _____ State: _____
County: _____ Zip: _____
Phone (1): _____ Phone (2): _____
DOB: ____/____/____ Age: _____
Sex: Male Female BMI: _____
Occupation: _____

Race (check all that apply):
 American Indian or Alaska Native Asian
 Native Hawaiian or Pacific Islander Black
 White Unknown
 Other: _____
Ethnicity:
 Hispanic or Latino Non-Hispanic Unknown
Physician Name: _____
Institution/Clinic: _____
City: _____ Phone: _____

B. CLINICAL ILLNESS HISTORY

Symptoms:

Cough Yes No
Coughing up blood Yes No
Non-healing skin sores Yes No
Poor appetite Yes No
Weight loss Yes No #lbs. _____
Headache Yes No
Back pain Yes No
Chest pain Yes No
Bone pain Yes No
Joint pain Yes No
Fever Yes No temp. ____ F
Chills Yes No
Night sweats Yes No
Fatigue Yes No
Other: _____

Illness onset date: ____/____/____
First visit to health care provider: ____/____/____
Patient hospitalized? Yes No
If yes, hospital name: _____
Admit date: ____/____/____
Discharge date: ____/____/____
Treatment:
 Itraconazole Fluconazole
 Voriconazole Amphotericin B
 Other: _____
Patient status at time of reporting:
 Alive Dead Date of death: ____/____/____
Death result of blastomycosis? Yes No
If no, cause: _____

Patient immunocompromised? Yes No

C. DIAGNOSTIC INFORMATION

Lab name:	Collection date:	Specimen:	Value or findings:	Result:
Antigen:	____/____/____	<input type="checkbox"/> Urine <input type="checkbox"/> Serum	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Cytology/Smear:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Culture:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Serology/Antibody:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Histopathology:	____/____/____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Radiology:	____/____/____	_____	_____	_____

D. CASE SUMMARY

Type of blastomycosis:
 Pulmonary, disease present only in the lungs
 Non-pulmonary, no disease in lungs
 Disseminated, both pulmonary and non-pulmonary disease

If non-pulmonary or disseminated, please mark all locations affected:
 Bone Skin Eye CNS
 Other location: _____