



Onset date: \_\_\_/\_\_\_/\_\_\_

Report date: \_\_\_/\_\_\_/\_\_\_

DEMOGRAPHIC INFORMATION	LABORATORY AND FACILITY INFORMATION
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**Name**  
**Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**DOB:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_ Days Months Years  
**Gender:** Male Female Transgender Unknown

**Medical record #:** \_\_\_\_\_

**Preferred language:** English Other: \_\_\_\_\_

**Country of birth:** U.S. Other: \_\_\_\_\_ Unknown

**Address:** \_\_\_\_\_  
Unknown Homeless

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Phone 1st:** \_\_\_\_\_ **Phone 2nd:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Parent/Guardian:** \_\_\_\_\_

**Reporter:**  
**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Institution/Clinic:** \_\_\_\_\_  
**City:** \_\_\_\_\_

**Ordering provider:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Primary care provider:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Lab Name:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

MDH contact if additional information needed (choose at least one):  
Reporter Primary care provider Ordering provider Lab  
Other: \_\_\_\_\_

**Ethnicity:**  
Hispanic/Latino  
Non-Hispanic/Non-Latino  
Unknown

**Race (check all that apply):**  
American Indian/Alaskan Native Asian  
Black/African American White  
Native Hawaiian/Pacific Islander Unknown  
Other: \_\_\_\_\_

**Was the patient hospitalized?** Yes No Unknown

**Hospital name:** \_\_\_\_\_

**Admit date:** \_\_\_/\_\_\_/\_\_\_ **Discharge date:** \_\_\_/\_\_\_/\_\_\_

**Died?** Yes No Unknown **If yes, date of death:** \_\_\_/\_\_\_/\_\_\_

**Specimen collection date:** \_\_\_/\_\_\_/\_\_\_

**Specimen source:** \_\_\_\_\_

**Pregnant (if applicable):** Yes No Unknown  
**If yes, due date:** \_\_\_/\_\_\_/\_\_\_

**PERTUSSIS SPECIFIC INFORMATION**

**Attend school or work:**  Yes  No  Unknown **If yes, school name and/or work location:** \_\_\_\_\_

**Childcare attendee/worker:**  Yes  No  Unknown **If yes, childcare center name:** \_\_\_\_\_

**Did the patient have:**

<p><b>Cough</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Paroxysmal cough</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Apnea</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Acute encephalopathy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Diagnosed with pneumonia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Xray for pneumonia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p><b>If yes, cough onset date:</b> ___/___/___</p> <p><b>Whoop</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Post-tussive vomiting</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Seizures</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>If yes, xray findings</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative  <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown</p>
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**Antibiotics prescribed:**  Yes  No  Unknown

**1<sup>st</sup> Antibiotic:**  Erythromycin  Clarithromycin/azithromycin  Tetracycline/doxycycline  Other: \_\_\_\_\_  Unknown  
 Date started: \_\_\_/\_\_\_/\_\_\_ No. days prescribed: \_\_\_\_\_ Actual no. of days taken: \_\_\_\_\_

**2<sup>nd</sup> Antibiotic:**  Erythromycin  Clarithromycin/azithromycin  Tetracycline/doxycycline  Other: \_\_\_\_\_  Unknown  
 Date started: \_\_\_/\_\_\_/\_\_\_ No. days prescribed: \_\_\_\_\_ Actual no. of days taken: \_\_\_\_\_

**3<sup>rd</sup> Antibiotic:**  Erythromycin  Clarithromycin/azithromycin  Tetracycline/doxycycline  Other: \_\_\_\_\_  Unknown  
 Date started: \_\_\_/\_\_\_/\_\_\_ No. days prescribed: \_\_\_\_\_ Actual no. of days taken: \_\_\_\_\_

**Did the patient have any of the following underlying conditions prior to illness (check all that apply):**

Asthma  Cystic fibrosis  HIV/AIDS  Other respiratory illness, specify \_\_\_\_\_

Other, specify \_\_\_\_\_

**LABORATORY INFORMATION**

Was laboratory testing for pertussis done?  Yes  No  Unknown

**Culture Result:**  Positive  Negative  Indeterminate  Pending  Not Done  Parapertussis  Unknown  Other  
**Date specimen collected:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Laboratory name:** \_\_\_\_\_

**PCR Result:**  Positive  Negative  Indeterminate  Pending  Not Done  Parapertussis  Unknown  Other  
**Date specimen collected:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Laboratory name:** \_\_\_\_\_

**DFA Result:**  Positive  Negative  Indeterminate  Pending  Not Done  Parapertussis  Unknown  Other  
**Date specimen collected:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Laboratory name:** \_\_\_\_\_

**Serology (acute) Result:**  Positive  Negative  Indeterminate  Pending  Not Done  Parapertussis  Unknown  Other  
**Date acute specimen collected:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Laboratory name:** \_\_\_\_\_

**VACCINE HISTORY**

Has the patient ever received any doses of diphtheria (D), tetanus (T), and/or pertussis (P)-containing vaccine?  Yes  No  Unknown  
 If yes, date of last pertussis-containing vaccine prior to illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate the reason if the patient has not received 3 or more pertussis-containing vaccines:  
 Religious exemption  Medical contraindication  Philosophical exemption  Previous culture/MD confirmed pertussis  
 Parental refusal  Age < 7 months  Other  Unknown

Please complete for pertussis-containing vaccines:

Vaccination Date	Vaccine Type	Vaccine Manufacturer	Lot Number
1. ____/____/____	<input type="checkbox"/> DTP whole cell <input type="checkbox"/> DtaP or Dtap-Hib <input type="checkbox"/> DT/ Td <input type="checkbox"/> DTP-Hib Tetramune <input type="checkbox"/> Tdap <input type="checkbox"/> Pertussis only <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Aventis <input type="checkbox"/> Connaught <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Lederle <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Wyeth <input type="checkbox"/> MA Dept of Health <input type="checkbox"/> MI Dept of Health <input type="checkbox"/> North American Vaccine <input type="checkbox"/> Unknown	_____
2. ____/____/____	<input type="checkbox"/> DTP whole cell <input type="checkbox"/> DtaP or Dtap-Hib <input type="checkbox"/> DT/ Td <input type="checkbox"/> DTP-Hib Tetramune <input type="checkbox"/> Tdap <input type="checkbox"/> Pertussis only <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Aventis <input type="checkbox"/> Connaught <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Lederle <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Wyeth <input type="checkbox"/> MA Dept of Health <input type="checkbox"/> MI Dept of Health <input type="checkbox"/> North American Vaccine <input type="checkbox"/> Unknown	_____
3. ____/____/____	<input type="checkbox"/> DTP whole cell <input type="checkbox"/> DtaP or Dtap-Hib <input type="checkbox"/> DT/ Td <input type="checkbox"/> DTP-Hib Tetramune <input type="checkbox"/> Tdap <input type="checkbox"/> Pertussis only <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Aventis <input type="checkbox"/> Connaught <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Lederle <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Wyeth <input type="checkbox"/> MA Dept of Health <input type="checkbox"/> MI Dept of Health <input type="checkbox"/> North American Vaccine <input type="checkbox"/> Unknown	_____
4. ____/____/____	<input type="checkbox"/> DTP whole cell <input type="checkbox"/> DtaP or Dtap-Hib <input type="checkbox"/> DT/ Td <input type="checkbox"/> DTP-Hib Tetramune <input type="checkbox"/> Tdap <input type="checkbox"/> Pertussis only <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Aventis <input type="checkbox"/> Connaught <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Lederle <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Wyeth <input type="checkbox"/> MA Dept of Health <input type="checkbox"/> MI Dept of Health <input type="checkbox"/> North American Vaccine <input type="checkbox"/> Unknown	_____
5. ____/____/____	<input type="checkbox"/> DTP whole cell <input type="checkbox"/> DtaP or Dtap-Hib <input type="checkbox"/> DT/ Td <input type="checkbox"/> DTP-Hib Tetramune <input type="checkbox"/> Tdap <input type="checkbox"/> Pertussis only <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Aventis <input type="checkbox"/> Connaught <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Lederle <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Wyeth <input type="checkbox"/> MA Dept of Health <input type="checkbox"/> MI Dept of Health <input type="checkbox"/> North American Vaccine <input type="checkbox"/> Unknown	_____
6. ____/____/____	<input type="checkbox"/> DTP whole cell <input type="checkbox"/> DtaP or Dtap-Hib <input type="checkbox"/> DT/ Td <input type="checkbox"/> DTP-Hib Tetramune <input type="checkbox"/> Tdap <input type="checkbox"/> Pertussis only <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Aventis <input type="checkbox"/> Connaught <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Lederle <input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> Wyeth <input type="checkbox"/> MA Dept of Health <input type="checkbox"/> MI Dept of Health <input type="checkbox"/> North American Vaccine <input type="checkbox"/> Unknown	_____

**EPIDEMIOLOGIC INFORMATION**

Is the source of the infection known?  Yes  No  Unknown  
 If known, source's relationship to the patient:  Mother  Father  Sister  Brother  Neighbor  Daycare  Grand parent  Friend  
 Other relative  Babysitter (non-daycare)  Other  Unknown  
 Source's sex:  Male  Female  Unknown **Source's age:** \_\_\_\_\_  Years  Weeks  Months  Days  
 If known, where did the patient acquire pertussis? \_\_\_\_\_  
 Is the patient related to an outbreak of pertussis?  Yes  No  Unknown  
 If yes, identify outbreak (e.g., school, daycare name): \_\_\_\_\_