Patient's Name _____ Telephone No. _____

Address _____ (Detach top portio

Please fax completed reports to the Minnesota Department of Health at 651-201-5743.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333

FORM APPROVED
OMB NO. 0920-0107

TOXIC - SHOCK SYNDROME CASE REPORT

The First Three Letters of Patient's Last Name (1-3) ☐☐☐ | CDC No. (4-8) ☐☐☐☐☐ | State No. (9-10) ☐☐ | State Case No. (11-15) ☐☐☐☐☐

Age (16-17) ☐☐

Date of Birth: Mo. (18-19) ☐☐ Day (20-21) ☐☐ Yr. (22-23) ☐☐

Sex (24): Male ☐ 1 Female ☐ 2

Outcome (25): Lived ☐ 1 Died ☐ 2

Race/Ethnicity (26): ☐ 1 White (not Hispanic) ☐ 2 Black (not Hispanic) ☐ 3 Hispanic ☐ 4 Asian/Pacific Islander ☐ 5 American Indian/Alaskan Native ☐ 9 Not Specified

Date of Onset of Symptoms: Mo. (27-28) ☐☐ Day (29-30) ☐☐ Yr. (31-32) ☐☐

Date of Onset of Coincident Menstrual Period (if applicable): Mo. (33-34) ☐☐ Day (35-36) ☐☐ Yr. (37-38) ☐☐

Admitted to Hospital (39): Yes ☐ 1 No ☐ 2 Unk ☐ 9

Date of Hospital Admission: Mo. (40-41) ☐☐ Day (42-43) ☐☐ Year (44-45) ☐☐

CASE CLASSIFICATION (46): Menstruation-associated ☐ 1 Wound-associated ☐ 2 Postpartum-associated ☐ 3 Other ☐ 4 (specify) _____

No. days postpartum ☐☐ (47-48)

CLINICAL FINDINGS Major Criteria

Fever (highest-if not recorded, leave blank) ☐☐☐.☐ F (49-52)

Hypotension (lowest) Systolic ☐☐☐ (53-55) Diastolic ☐☐ (56-57)

Syncope Yes ☐ 1 No ☐ 2 (58)

Orthostatic dizziness Yes ☐ 1 No ☐ 2 (59)

Rash (60) Yes ☐ 1 No ☐ 2 Unk. ☐ 9 (61) If yes, Generalized ☐ 1 Focal ☐ 2 Describe: _____

Desquamation (62) Yes ☐ 1 No ☐ 2 Unk. ☐ 9 If yes, describe: _____

SIGNS AND SYMPTOMS (First 4 Days of Illness)

	YES 1	NO 2	UNK 9		YES 1	NO 2	UNK 9		YES 1	NO 2	UNK. 9
(63) Vomiting	☐	☐	☐	(68) Conjunctival hyperemia	☐	☐	☐	(73) Vaginal ulceration	☐	☐	☐
(64) Diarrhea	☐	☐	☐	(69) Oropharyngeal hyperemia	☐	☐	☐	(74) Disorientation	☐	☐	☐
(65) Abdominal pain	☐	☐	☐	(70) Injected tongue	☐	☐	☐	(75) Seizures	☐	☐	☐
(66) Myalgia	☐	☐	☐	(71) Vaginal hyperemia	☐	☐	☐	(76) Cardiac Arrhythmia	☐	☐	☐
(67) Sore throat	☐	☐	☐	(72) Vaginal discharge	☐	☐	☐	If Yes, describe _____			

LABORATORY DATA (Most Abnormal Values in First 4 Days of Illness)

			Not Obtained
WBC Count (77-79)	☐☐.☐	000/mm³	(80) ☐
(81-82) Neutrophils	☐☐	%	(83) ☐
(84-85) Bands	☐☐	%	(86) ☐
(87-88) Metamyelocytes	☐☐	%	(89) ☐
(90-91) Myelocytes	☐☐	%	(92) ☐
(93-95) Platelets	☐☐☐	000/mm³	(96) ☐
(97-99) Highest platelet value after 7 days of illness	☐☐☐	000/mm³	
(100-102) SGOT	☐☐☐	IU/L	(103) ☐
(104-106) SGPT	☐☐☐	IU/L	(107) ☐
(108-110) Alkaline phosphatase	☐☐☐	IU/L	(111) ☐
(112-114) Bilirubin	☐☐.☐	mg/dl	(115) ☐
(116-119) Amylase	☐☐☐☐	Somogyi Units/dl	(120) ☐

Urinalysis

			Not Obtained
(121-122) WBC/HPF	☐☐	("Many" = 99)	(123) ☐
(124-125) RBC/HPF	☐☐	("Many" = 99)	(126) ☐
(127) Protein (0-4+)	☐		(128) ☐
(129-130) BUN	☐☐	mg/dl	(131) ☐
(132-134) Creatinine	☐☐.☐	mg/dl	(135) ☐
(136-138) Calcium	☐☐.☐	mg/dl	(139) ☐
(140-141) Phosphorus	☐.☐	mg/dl	(142) ☐
(143-144) Albumin	☐.☐	g/dl	(145) ☐
(146-149) Creatine phosphokinase (CPK)	☐☐☐☐	IU/L	(150) ☐
(151) CPK-myocardial band	Yes ☐ 1 No ☐ 2 Unk ☐ 9		(152) ☐

(153) EKG Normal ☐ 1 Abnormal ☐ 2 Not obtained ☐ 3 Unk. ☐ 9 If Abnormal, describe _____

(154) Chest X-Ray Normal ☐ 1 Abnormal ☐ 2 Not obtained ☐ 3 Unk. ☐ 9 If Abnormal, describe _____

This report is authorized by law (Public Health Service Act, 42
Epidemiologists. While your response is voluntary, your coopera

efore sending to CDC.)

Physician's Name _____ Telephone No. _____

Address _____ Hospital

CULTURES

BLOOD (155) Positive ☐ 1 Negative ☐ 2 Not Done ☐ 3 Unk ☐ 9 If Positive, what organism(s): 1 _____ (156-157) 2 _____ (158-159)

URINE (160) Positive ☐ 1 Negative ☐ 2 Not Done ☐ 3 Unk ☐ 9 If Positive, what organism(s): 1 _____ (161-162) 2 _____ (163-164)

Colony Count 1. ☐☐☐ 000/ml (165-167) 2. ☐☐☐ 000/ml (168-170)

THROAT (171) Normal Flora ☐ 1 Abnormal ☐ 2 Not Done ☐ 3 Unk ☐ 9 If Abnormal, what organism(s): 1 _____ (172-173) 2 _____ (174-175)

NARES (176) Done ☐ 1 Not Done ☐ 3 Unk ☐ 9 If Done, what organism(s): 1 _____ (177-178) 2 _____ (179-180)

VAGINA (181) Done ☐ 1 Not Done ☐ 3 Unk ☐ 9 If Done, what organism(s): 1 _____ (182-183) 2 _____ (184-185)

Was *Staphylococcus aureus* present in the vagina? (186) Yes ☐ 1 No ☐ 2 Unk ☐ 9

If *S. aureus* present in vagina, is it resistant to penicillin and ampicillin only? (187) Yes ☐ 1 No ☐ 2 Unk ☐ 9

Other Site(s) _____ (188-189) Organism(s) 1. _____ (190-191) 2. _____ (192-193)

Was patient taking antibiotics when culture(s) performed? (194) Yes ☐ 1 No ☐ 2 Unk. ☐ 9 If yes, which sites? _____ (195-196)

TAMPON/NAPKIN/MINIPAD USE – IF APPLICABLE (During Period When Patient Became Ill)

PRODUCTS USED (197-198)

Tampon only ☐ 1 Minipad only ☐ 3 Tampon and Minipad ☐ 5 Tampon, Napkin, and Minipad ☐ 7 Other _____ (199-200) ☐ 10

Napkin only ☐ 2 Tampon and Napkin ☐ 4 Napkin and Minipad ☐ 6 Sea Sponge ☐ 8 Unknown ☐ 9

(If Only One Brand Was Used Before Onset of Symptoms, List Only That Brand)

BRAND #1 (Most frequently used, judged by time)

NAME (201-202)

- Assure ☐ 1
- Kotex
  - Plastic Inserter ☐ 2
  - Stick Inserter ☐ 3
  - Inserter Unk ☐ 4
- o.b. ☐ 5
- Playtex
  - Deodorized ☐ 6
  - Non-deodorized ☐ 7
  - Deodorant unk ☐ 8
- Pursettes ☐ 10
- Rely ☐ 11
- Tampax ☐ 12
- Other(specify) _____ ☐ 13
- Unknown ☐ 9

STYLE(ABSORBENCY) (203)

- Super-plus ☐ 1
- Super ☐ 2
- Regular ☐ 3
- Junior ☐ 4
- Unknown ☐ 9

BRAND #2

NAME (204-205)

- Assure ☐ 1
- Kotex
  - Plastic inserter ☐ 2
  - Stick inserter ☐ 3
  - Inserter unk ☐ 4
- o.b. ☐ 5
- Playtex
  - Deodorized ☐ 6
  - Non-deodorized ☐ 7
  - Deodorant unk ☐ 8
- Pursettes ☐ 10
- Rely ☐ 11
- Tampax ☐ 12
- Other (specify) _____ ☐ 13
- Unknown ☐ 9

STYLE(ABSORBENCY) (206)

- Super-plus ☐ 1
- Super ☐ 2
- Regular ☐ 3
- Junior ☐ 4
- Unknown ☐ 9

Was Brand No. 1 the only tampon brand used during period when patient became ill? (207) Yes ☐ 1 No ☐ 2 Unk. ☐ 9

NAPKIN BRAND: _____ (208-209)

MINIPAD BRAND: _____ (210-211)

How was information in this section verified? (212)

- Patient's Memory ☐ 1
- Patient viewing product box ☐ 2
- Interviewer viewing product box ☐ 3
- Other (describe) ☐ 4

RECURRENCE INFORMATION FOR MENSTRUATION-ASSOCIATED CASES

Has patient had similar illness in past during menstrual period? (213) Yes ☐ 1 No ☐ 2 Unk. ☐ 9 If yes, how many episodes? (214) One ☐ 1 Two ☐ 2 Three ☐ 3 More than Three ☐ 4

OTHER INFORMATION

Please describe any other pertinent or unusual features of this case _____

How was case reported to Health Department? (215) By patient or relative ☐ 1 By physician ☐ 2 By hospital ☐ 3 Other ☐ 4

Person Completing Form	Date Reported to Health Department (216-221)	Date Form Completed (222-227)

FOR CDC USE ONLY ☐ 1 ☐ 2 ☐ 3 ☐ 4 (228)

and is also recommended by the Conference of State and Territorial