NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division in the National Health Laboratory Service

Special Viral Pathogens Laboratory: +2711 386 6336 (or +2782 903 9131)
NICD Hotline for Clinical Advice: +27 800 212 552

YELLOW FEVER SUSPECTED CASE HISTORY FORM

Filled in by: ____________________ Contact number: ____________________
Date: __/__/____ Information collected from: ____________________

PATIENT INFORMATION

Name: ____________________
Age: ______ Years Birth date: __/__/____
Sex: M ☐ F ☐ If female, pregnant? YES ☐ NO ☐
Address: ____________________
____
Referring physician: ____________________
Number for physician: ____________________
____

PATIENT COURSE

	YES	NO	DATE	
Patient hospitalised?	☐	☐	__/__/____	(If admitted)
Hospital name: ____________				(If admitted)
	☐	☐	__/__/____	(If discharged)
Patient is alive?	☐	☐	__/__/____	(If deceased)

Treatment(s) given? ____________________
____
____

CLINICAL FEATURES AND PATHOLOGICAL FINDINGS

(Tick appropriate box (yes; no; UNK: unknown)

Date(s) of onset: __/__/____ __/__/____

Symptoms	YES	NO	UNK	**Signs - Complications**	YES	NO	UNK	**Pathology tests**	YES	NO	UNK
Fever ___ °C	☐	☐	☐	Reduced consciousness	☐	☐	☐	Malaria negative	☐	☐	☐
Chills	☐	☐	☐	Jaundice - Yellow eyes	☐	☐	☐	Platelets<100,000	☐	☐	☐
Headache	☐	☐	☐	Hepatomegalomy	☐	☐	☐		**count**	**unit**	**date**
Malaise	☐	☐	☐	Renal failure	☐	☐	☐	Lowest Plts. count:		10^9/L	__/__/____
Nausea	☐	☐	☐	Arrhythmia	☐	☐	☐	Lowest WBC count:		10^9/L	__/__/____
Vomiting	☐	☐	☐	Rash (If yes, describe)	☐	☐	☐	Lowest serum ALB:		g/L	__/__/____
Diarrhoea	☐	☐	☐					Lowest BP:		mmHG	__/__/____
Abdominal pain	☐	☐	☐	Petechiae /Purpura/ecchymosis	☐	☐	☐	Highest C-RP:		mg/L	__/__/____
Muscle pain	☐	☐	☐	Overt bleeding	☐	☐	☐	Highest AST:		U/L	__/__/____
Joint pain	☐	☐	☐	(If yes, describe from where):				Highest ALT:		U/L	__/__/____
Back pain	☐	☐	☐					AST/ALT:		10^9/L	__/__/____
Neckstiffness	☐	☐	☐	Seizures	☐	☐	☐	Total Bilirubin:		mg/dL	__/__/____

Other Findings: ____________________
____

PATIENT TRAVEL and EXPOSURE HISTORY

	YES	NO	UNK
Does the patient have a history of travel outside South Africa?	☐	☐	☐
If yes, Within 30 days prior to onset?	☐	☐	☐

Date(s) From: __/__/____ Until: __/__/____ Travelled to: ____________ (country)
____________ (where within country)

Travel purpose: ☐ Holiday ☐ Visiting relative ☐ business ☐ Other, state: ____________

Has the patient received any bites?
☐ Mosquito bites ☐ Tick bites ☐ Animal bites ☐ No bites ☐ Unknown If yes, give date: __/__/____
If yes, give details: ____________________

PATIENT VACCINATION RECORD

Did patient receive yellow fever vaccination? *(Tick appropriate box)*
☐ ≥ 30 days prior to travel to yellow fever declared country
☐ ≥ 10 days prior to travel to yellow fever declared country
☐ < 10 days prior to travel to yellow fever declared country
☐ Never travelled to yellow fever declared country
☐ Never received vaccination but travelled in past to yellow fever declared country
☐ Unknown

(If vaccinated, specify countries and dates)
Countries: ____________
____
____
Date(s): __/__/____
Last vaccinated __/__/____

POST COMPLETED FORM WITH SPECIMEN TO:
Special Viral Pathogens Lab, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa

EMAIL COMPLETED FORM TO:
jacquelinew@nicd.ac.za
naazneenm@nicd.ac.za