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| **CASE INVESTIGATION FORM: MPOX** |
| **I. PATIENT DETAILS** |
| Surname:  |       | Name/s: |       |
| Date of birth: | DD / MM / YYYY | Age: |  | Sex:  | Male [ ]  | Female [ ]  |
| Contact Tel./Cell:  | (000) 0000000 | (000) 0000000 | Occupation: |       |
| Physical home address: |       |
| **II. ATTENDING HEALTHCARE WORKER AND HEALTHCARE FACILITY DETAILS** |
| Name of clinician:  |       | Contact Tel./Cell clinician: | -0 |
| Healthcare facility name:  |       | Location of healthcare facility: |       |
| Hospital case nr.:  |       | Date of admission: | DD / MM / YYYY | Ward: |       |
| **III. RISK FACTORS/ EXPOSURE HISTORY – during the 21 days prior to onset of symptoms** |
| Close contact with suspected or confirmed case of monkeypox\*  | Yes [ ]   | No [ ]  | Unknown [ ]  |
| History of international travel to country reporting monkeypox in 21 days prior to onset of illness  | Yes [ ]   | No [ ]  | Unknown [ ]  |
| Date of exposure/possible exposure: | DD / MM / YYYY |
| Place of exposure/possible exposure: |            |
| Type of exposure\*\* (Tick appropriate exposure type):  | 1 [ ]  | 2 [ ]  | 3 [ ]  | 4 [ ]  |
| **IV. CLINICAL INFORMATION** |
| 1. **Date of onset of illness:**
 | DD / MM / YYYY |
| 1. **Clinical features** (Tick appropriate box: yes, no, unknown)
 |
| Fever  | Yes [ ]   | No [ ]   | Unknown [ ]  | Rash  | Yes [ ]  | No [ ]  | Unknown [ ]  |
| If yes, specify temperature |       | °C | Date of onset of rash | DD / MM / YYYY |
| Lymphadenopathy  | Yes [ ]   | No [ ]   | Unknown [ ]  | Distribution of rash: |
| Headache  | Yes [ ]   | No [ ]   | Unknown [ ]  | Face [ ]  | Oral [ ]  | Arms[ ]  | All over |
| Muscle pain  | Yes [ ]   | No [ ]   | Unknown [ ]  | Trunk [ ]  | Genitals [ ]  | Legs [ ]   | body [ ]  |
| Fatigue  | Yes [ ]   | No [ ]   | Unknown [ ]  | Thorax [ ]  | Soles of hands [ ]  | Soles of feet [ ]  |
| Sore throat  | Yes [ ]   | No [ ]   | Unknown [ ]  | Type of rash:  | Macular | Yes [ ]  | No [ ]  |
| Nausea/vomiting  | Yes [ ]   | No [ ]   | Unknown [ ]  |  | Maculopapular | Yes [ ]  | No [ ]  |
| Cough  | Yes [ ]   | No [ ]   | Unknown [ ]  |  | Vesicular | Yes [ ]  | No [ ]  |
| Chills/sweats  | Yes [ ]   | No [ ]   | Unknown [ ]  |  | Petechial | Yes [ ]  | No [ ]  |
| Light sensitivity  | Yes [ ]   | No [ ]   | Unknown [ ]  |  | Vasculitis | Yes [ ]  | No [ ]  |
| Other, specify:  |       |
| If female, pregnant:  | Yes [ ]   | No [ ]   | Unknown [ ]  | n/a (male) [ ]  |
| **V. PAST** **MEDICAL AND TRAVEL HISTORY** |
| Underlying illness\*\*\*  | Yes [ ]  | No [ ]  | Unknown [ ]  |
| If yes, give details: |       |
| Country/ies visited: | Location/s visited within country:  | Date of arrival:  | Date departure: |
|       |       | DD / MM / YYYY | DD / MM / YYYY |
| Activities at the location/purpose of travel: |       |