|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |