

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name _____		Social Security Number ____-____-____		Ethnicity (✓ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
First Name/Middle Name (or initial) _____		Birth Date Month Day Year ____/____/____		Age ____	
Address: Number, Street _____				Apt./Unit Number _____	
City/Town _____		State ____	ZIP Code ____-____		
Area Code ____	Home Telephone ____-____-____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	Estimated Delivery Date Month Day Year ____/____/____	
Area Code ____	Work Telephone ____-____-____	Patient's Occupation/Setting <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other _____			Race (✓ one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (✓ one): <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other: _____
<input type="checkbox"/> Native American/Alaskan Native	<input type="checkbox"/> White: _____	<input type="checkbox"/> Other: _____			

DATE OF ONSET Month Day Year ____/____/____		Reporting Health Care Provider _____		REPORT TO	
DATE DIAGNOSED Month Day Year ____/____/____		Reporting Health Care Facility _____			
DATE OF DEATH Month Day Year ____/____/____		Address _____			
Telephone Number () () _____	Fax () () _____	City _____ State ____ ZIP Code ____-____			
Submitted by _____	Date Submitted (Month/Day/Year) ____/____/____				

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STD)			VIRAL HEPATITIS																																																												
Syphilis <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Secondary <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Congenital <input type="checkbox"/> Latent (unknown duration)			Syphilis Test Results <input type="checkbox"/> RPR Titer: _____ <input type="checkbox"/> VDRL Titer: _____ <input type="checkbox"/> FTA/MHA: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other: _____		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th>Pend</th> <th>Not Done</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Hep A anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep B anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Acute anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chronic anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep C anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Acute PCR-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chronic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep D (Delta) anti-Delta</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>			Pos	Neg	Pend	Not Done	<input type="checkbox"/> Hep A anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hep B anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acute anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hep C anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acute PCR-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hep D (Delta) anti-Delta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suspected Exposure Type <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Other needle exposure <input type="checkbox"/> Sexual contact <input type="checkbox"/> Household contact <input type="checkbox"/> Child care <input type="checkbox"/> Other: _____	
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Gonorrhea <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____			Chlamydia <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____		<input type="checkbox"/> PID (Unknown Etiology) <input type="checkbox"/> Chancroid <input type="checkbox"/> Non-Gonococcal Urethritis																																																										
STD TREATMENT INFORMATION <input type="checkbox"/> Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated: ____/____/____			<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____																																																												

TUBERCULOSIS (TB) Status <input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Convertor <input type="checkbox"/> Reactor		Mantoux TB Skin Test Date Performed: ____/____/____ Results: _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done		Bacteriology Date Specimen Collected: ____/____/____ Source: _____ Smear: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done BCG Vaccine Given? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, at what age/year? _____ Other test(s): _____		TB TREATMENT INFORMATION <input type="checkbox"/> Current Treatment <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/> EMB <input type="checkbox"/> Other: _____ Date Treatment Initiated: ____/____/____	
Site(s) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both		Chest X-Ray Date Performed: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory				<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____	

REMARKS

