WORKSHEET: EVALUATING PATIENTS FOR SMALLPOX

Identification Number _____
Person Completing Form _____
Date of Contact with Case _____
Today's Date (mo/da/yr) _____

PATIENT INFORMATION

Name:
_____
LAST FIRST MIDDLE INITIAL

Date of Birth: ___/___/___ **Age:** ___ **Sex:** ☐ Male ☐ Female

Telephone:
Home _____ Other _____

Address: _____
_____
CITY STATE ZIP

Where is the patient now? ☐ Home ☐ Doctor's Office
☐ Emergency Room *(if checked, continue below)*
☐ Hospital *(if checked, continue below)*
☐ Other *(specify)* _____

Hospital Name _____
City/State _____
Admission Date ___/___/___ Discharge Date ___/___/___
Hospital Telephone Number ( ) _____

Race: ☐ White ☐ Black ☐ Asian ☐ Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic **Country of Birth:** _____

PROVIDER INFORMATION

Name: _____
Patient Population Specialty: _____
☐ Adult ☐ Peds ☐ Both
Telephone:
Type _____ ( ) _____
Type _____ ( ) _____
E-mail Address: _____

Name: _____
Patient Population Specialty: _____
☐ Adult ☐ Peds ☐ Both
Telephone:
Type _____ ( ) _____
Type _____ ( ) _____
E-mail Address: _____

CLINICAL INFORMATION

PRODROME / SYMPTOMS 1-4 DAYS BEFORE RASH ONSET

Did the patient have a fever and other illness 1-4 days before rash onset? ☐ Yes ☐ No ☐ Unknown

Date of prodrome onset ___/___/ 200__

If *Yes*, on what date did the patient first have a fever? ___/___/___

What was the highest temperature? _____ °F or _____ °C

On what date: ___/___/___

Check all features of the prodrome that apply:
☐ No/Mild prodrome (<1 day)
☐ Headache
☐ Backache
☐ Chills
☐ Vomiting
☐ Abdominal pain
☐ Sore throat*
☐ Other *(specify)* _____

*In infants, this may manifest as drooling or refusing to eat or drink.

Was the patient toxic or seriously ill? ☐ Yes ☐ No ☐ Unknown

Was the patient able to do most normal activities? ☐ Yes ☐ No ☐ Unknown

RASH

Date of rash onset ___/___/ 200__

Was the rash acute (sudden) in onset? ☐ Yes ☐ No ☐ Unknown

Was a black scar (eschar) present before or at the time of appearance of the rash? ☐ Yes ☐ No ☐ Unknown

Is the rash *generalized* (i.e., multiple parts of the body) or *focal* (i.e., only one part of the body)? ☐ Generalized ☐ Focal

Where on the body were the first lesions noted?
☐ Face
☐ Trunk
☐ Inside the mouth
☐ Other *(specify)* _____
☐ Arms
☐ Legs
☐ Unknown

Since rash onset, where on the body was the rash most dense?
☐ Trunk
☐ Face or scalp
☐ Distal extremities (arms, legs)
☐ Equally distributed everywhere
☐ Other *(describe)* _____

Are there any lesions on the palms or soles? ☐ Yes ☐ No ☐ Unknown

What kind of lesions does the patient have now? *(check all that apply)*
☐ Macules (flat, reddish spots)
☐ Papules (solid bumps)
☐ Vesicles (fluid-filled blisters)
☐ Pustules (blisters filled with pus)
☐ Crusts
☐ Other _____

If more than one kind of lesion, which kind of lesion is now the most common? _____

Are the lesions now:
☐ Superficial (on top of the skin)
☐ Deep (feel embedded deeply in the skin)
☐ Neither *(describe)* _____

How many lesions are present? (in total) _____

If no precise count is available, please estimate:
☐ <20
☐ 20-50 (able to count in less than a minute)
☐ 51-499 (typically an average case of varicella has 200-400 lesions)
☐ >500 (lesions confluent in some places, can't see normal skin between)

On any one part of the body (e.g., face or arm), are all the lesions in the same state of development? ☐ Yes ☐ No ☐ Unknown

How big are most of the lesions? *(Do not measure superinfected lesions.)*
☐ Small (1-5 mm)
☐ Large (5-10 mm)
☐ Neither *(describe)* _____

Have any lesions crusted? ☐ Yes ☐ No ☐ Unknown

If *Yes*, how many days did it take for the first lesions to crust? _____

How itchy is the rash? ☐ Not at all ☐ Somewhat ☐ Very ☐ Unknown

Does the patient have lymphadenopathy? ☐ Yes ☐ No ☐ Unknown

If *Yes*, describe: _____

Is the patient toxic or moribund now? ☐ Yes ☐ No ☐ Unknown

If *Yes*, describe: _____

Continues

CLINICAL NOTES

SOURCE / EXPOSURE INFORMATION

Is chickenpox (varicella) occurring in the community? ☐ Yes ☐ No ☐ Unknown

Has the patient had contact with a person with chickenpox or shingles 10-21 days before rash onset? ☐ Yes ☐ No ☐ Unknown

If *Yes*, give date(s) and type of contact: _____

Within the past three (3) weeks: *(applies to remainder of section)*

Has the patient been in contact with a person with any other rash illness? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please specify, with date: _____

Has the patient traveled in this time period before onset of illness? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please provide locations and dates of travel:

Place: _____ Dates: _____

Place: _____ Dates: _____

Has the patient had contact with mice? ☐ Yes ☐ No ☐ Unknown

Has the patient been camping, hiking, or exposed to woods before onset of illness? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please provide details and dates:

_____ Dates: _____

_____ Dates: _____

Has the patient received insect bites? ☐ Yes ☐ No ☐ Unknown

Has the patient been exposed to ticks? ☐ Yes ☐ No ☐ Unknown

VACCINATION HISTORY

Has the patient received chickenpox (varicella) vaccine? ☐ Yes ☐ No ☐ Unknown
(Chickenpox vaccine was licensed in the United States in 1995.)

If *Yes*, dose #1 date ____/____/____ or age _____

dose #2 date ____/____/____ or age _____
(only persons >13 years receive a second dose)

Has the patient ever received smallpox vaccine? ☐ Yes ☐ No ☐ Unknown
(The smallpox vaccine was routinely given in the U.S. until 1972, was recommended for health care providers until 1976, was administered in the military until 1990.)

If *Yes*, when was the most recent vaccination? ____/____/____
or at what age? _____

MEDICAL HISTORY

Has the patient ever had chickenpox or shingles? ☐ Yes ☐ No ☐ Unknown

If *Yes*, when? ____/____/____ or at what age? _____

Is the patient immunocompromised? ☐ Yes ☐ No ☐ Unknown

If *Yes*, specify type of illness *(e.g., cancer, HIV/AIDS)* _____

Does the patient have any other serious underlying medical illnesses? *(e.g., asthma)* ☐ Yes ☐ No ☐ Unknown

If *Yes*, please list: _____

Is the patient sexually active? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

DIFFERENTIAL DIAGNOSIS

MEDICATIONS

Is the patient on medications that suppress the immune system? *(e.g., steroids, chemotherapy, radiation)* ☐ Yes ☐ No ☐ Unknown

If *Yes*, name of medication: _____
Dosage: _____
Method of administration: _____

Is the patient taking antiviral medications? ☐ Yes ☐ No ☐ Unknown

If *Yes*, name of medication: _____
Dosage: _____
Method of administration: _____

Please list all prescription and non-prescription medications that the patient has taken in the past three weeks. *(List drug, dosage, route, dates)*

Is there a history of illicit drug use in the past three weeks? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please specify drug, amount (if known), route, and dates:

LABORATORY

Other lab testing — Please complete last page

Have you tested the patient for chickenpox? ☐ Yes ☐ No ☐ Unknown

If *Yes*, what type of test? _____

Results of tests: _____

Date: ____/____/____

Other comments: _____

DISPOSITION

Risk of smallpox
using CDC criteria (available at www.cdc.gov/nip/smallpox):

☐ **Low** ☐ **Moderate** ☐ **High*** ☐ **Unknown**
**If checked, see contact checklist below in Immediate Response Information*

IMMEDIATE RESPONSE INFORMATION

- ☐ Institute airborne and contact precautions
- ☐ Alert infection control
- ☐ Take digital photographs of rash
- ☐ Consult ID and/or dermatology

IF THE PATIENT IS AT HIGH RISK:

☐ Contact local health department

Name: _____ Phone: _____

E-mail: _____ Phone: _____

☐ Contact state epidemiologist

Name: _____ Phone: _____

E-mail: _____ Phone: _____

☐ Contact state BT coordinator

Name: _____ Phone: _____

E-mail: _____ Phone: _____

☐ Contact CDC BT coordinator

Name: _____ Phone: _____

E-mail: _____ Phone: _____

24-HOUR FOLLOW-UP INFORMATION

Date of follow -up: ____/____/____

Person making follow-up: _____

Condition of patient: _____

Risk of smallpox 24 hours later: ☐ Low ☐ Moderate ☐ High ☐ Unkn

Action taken: _____

Diagnosis: _____

Was diagnosis confirmed? ☐ Yes ☐ No ☐ Unknown

How was diagnosis confirmed? _____

48-HOUR FOLLOW-UP INFORMATION

Date of follow -up: ____/____/____

Person making follow-up: _____

Condition of patient: _____

Risk of smallpox 24 hours later: ☐ Low ☐ Moderate ☐ High ☐ Unkn

Action taken: _____

Diagnosis: _____

Was diagnosis confirmed? ☐ Yes ☐ No ☐ Unknown

How was diagnosis confirmed? _____

72-HOUR FOLLOW-UP INFORMATION

Date of follow -up: ____/____/____

Person making follow-up: _____

Condition of patient: _____

Risk of smallpox 24 hours later: ☐ Low ☐ Moderate ☐ High ☐ Unkn

Action taken:

Diagnosis: _____

Was diagnosis confirmed? ☐ Yes ☐ No ☐ Unknown

How was diagnosis confirmed? _____

www.cdc.gov/nip/smallpox

CLINICAL NOTES

PLEASE LIST ALL LABORATORY TESTS ORDERED OR PERFORMED REGARDING THIS ILLNESS

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
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☐ Other ____________