**DISEASE INVESTIGATION FORM FOR VECTOR-BORNE**

Name of Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact No of Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructions:

***Suspect Zika case*** A patient with skin rash and one of the following: fever (<380c) or reported history of fever within the last days prior to consultation, arthralgia, arthritis, conjunctivitis

***Confirmed Zika Case*** is a suspect case of ZIKV virus (ZIKV) who tested positive in: Real-time PCR ( Polymerase Chain reaction), Virus isolation

in any body fluid

1. Write in capital letters
2. No abbreviations
3. Check corresponding box for answers
4. Fill out form completely
5. **DEMOGRAPHIC INFORMATION:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | | | | | **REMARKS** |
| **1** | **Full Name: Last Name, First Name, Middle Name** |  | | | | | |
| **2** | **Sex** | **🗆 male 🗆 female**  **IF Female, Pregnant : Age of Gestation:** | | | | |  |
| **3** | **Age** |  | | | | |  |
| **4** | **Date of Birth** | **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_** | | | | |  |
| **5** | **Civil Status** | **🗆 single 🗆 married 🗆 annulled 🗆 widowed 🗆 child** | | | | |  |
| **6** | **Religion** | **🗆 RC 🗆 Protestant 🗆 INC 🗆 Born Again 🗆 Others\_\_\_\_\_\_** | | | | |  |
| **7** | **Present Address** | **No: \_\_\_\_\_\_\_ St./Brgy.\_\_\_\_\_\_\_\_\_\_\_\_\_City/Municipality\_\_\_\_\_\_\_\_\_\_\_Province\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **8** | **Occupation** |  | | | | |  |
| **9** | **Work Place** | **Day time: Evening:** | | | | | **Week schedule** |
| **10** | **School (If student)** |  | | | | |  |
| **11** | **No. of occupants in your house** |  | | | | |  |
| **12** | **Member of the family who develop same signs and symptoms as the case** | | **Name** | **Age** | **DoB** | **Onset** |  |

1. **Clinical Information**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | | | | | | **REMARKS** | |
| **13** | **What is the first symptom experienced** | | | |  | | |  | |
| **14** | **Date when the first symptom appear** | | | | **\_\_/\_\_/\_\_\_\_ Time:\_\_\_\_AM/PM** | | |  | |
| **15** | **Did you seek consultation?** | **🗆 Yes 🗆 No** | | | | | |  | |
| **16** | **When did you seek consultation?** | | | | | **\_\_mm/\_\_dd/\_\_\_\_** | |  | |
| **17** | **Where did you seek consultation?** | **❑ Health Center ❑ Hospital ❑ Private MD/Clinic ❑ Faith Healer ❑ Others (please specify) \_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **18** | **Admitted** | **🗆 Yes 🗆 No** | | | | | |  | |
| **19** | **Date of admission** | **\_\_ mm/\_\_dd/\_\_\_\_year** | | | | | |  | |
| **20** | **Name of Hospital** |  | | | | | |  | |
| **21** | **Did you seek consultation for other diseases** | **🗆 Yes 🗆 No If yes, specify the disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **22** | **Did you have fever?** | **🗆 Yes 🗆 No Start date: \_\_\_mm/\_\_\_dd/\_\_\_year End: \_\_\_\_mm/\_\_\_dd/\_\_\_\_year** | | | | | | | |
| **23** | **Temperature & Duration of fever** | **\_\_\_\_\_°C \_\_\_\_\_days** | | | | | | | |
| **24** | **Type of fever\*** | **❑ Continuous ❑ Remittent ❑ Intermittent ❑ Low Grade ❑ Night Sweats ❑ others** | | | | | | | |
|  | **Occurrence of fever** | **❑ During night ❑ During Day ❑ Day and Night** | | | | | | | |
| **25** |  | **Yes** | **No** | **Date of Onset**  **MM/DD/YYYY** | | | **Date Ended**  **MM/DD/YYYY** | **No. of days** |  |
| **26** | **Skin Rash** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  | **❑ petechial ❑ macular ❑ papular**  **❑ pustular ❑ maculo-papular** |
| **27** | **Myalgia (Muscle pain)** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **28** | **Asthenia (generalized weakness)** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **29** | **Arthralgia (pain in a joint)** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **30** | **Lower Limb Edema** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **31** | **Periarticular Edema** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **32** | **Headache** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **33** | **Tingling sensations in the legs** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **34** | **Paralysis** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **35** | **Seizures** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **36** | **Back Pain** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **37** | **Non-purulent Conjunctivitis** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **38** | **Retro-orbital Pain** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **39** | **Abdominal Pain** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **40** | **Diarrhea** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **41** | **Others (specify)** | **❑** | **❑** | **\_\_/\_\_/\_\_\_** | | | **\_\_/\_\_/\_\_\_** |  |  |
| **42** | **Disease Outcome** | **❑ Recovered ❑ Still sick ❑ Died** | | | | | |  |  |

#### **\*Continuous Fever: The temperature remains above normal throughout the day and does not fluctuate more than 1 degree Celsius in 24 hours.**

#### **Remittent Fever: The temperature remains above normal throughout the day and fluctuates more than 2 degree Celsius in 24 hours.**

#### **Intermittent Fever: The temperature is present only for some hours in a day and remains to normal for the remaining hours.**

#### **Low Grade Fever: Temperature is present daily especially in the evening for several days but does not exceed 37.8 degree Celsius at any time.**

#### **Night Sweats: Rise in body temperature is evident in the evening hours or the patient may be woken up at night with sweating.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Q#** |  | **Type of LABORATORY EXAMINATION** | **REMARKS** |
| **35** | **Blood (Acute Phase)** |  |  |
| **36** | **Blood (Convalescent Phase)** |  |  |
| **37** | **Csf** |  |  |
| **38** | **Amniotic Fluid Samples (For Pregnant Women With Fetal Microcephaly)** |  |  |
| **39** | **Cord Blood** |  |  |
| **40** | **Placenta** |  |  |
| **41** | **Urine** |  |  |
| **42** | **Nps/Ops** |  |  |

1. **Exposure and History**

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| --- | --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | | **REMARKS** |
| **43** | **Bitten by mosquito?**  **Place where bitten**  **Body parts bitten**  **When date bitten by mosquito?** | **🗆 Yes 🗆 No**  **\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |
| **44** | **Do you know anyone from your family member or community who have been infected with dengue or chikungunya?** | **🗆 Yes 🗆 No If yes, Name of patient** | **Date of onset** |  |
| **45** | **History of sexual contact for the past 2 weeks; sex includes vaginal, anal, oral sex, and the sharing of sex toys.** | **🗆 Yes 🗆 No** | |  |
| **46** | **Do your sexual partner have history of travel outside Iloilo city or other country past 2 weeks?** | **🗆 Yes 🗆 No if yes, when?** | |  |
| **47** | **Has the patient received blood or blood products within the previous 30 days prior to symptoms onset?** | **🗆 Yes 🗆 No if yes, when?** | |  |
| **48** | **Have you been expose to human specimen such as blood product or body fluids in the laboratory?** | **🗆 Yes 🗆 No if yes, when?**  **Address of laboratory:** | |  |
| **49** | **Has the patient been in contact with a dengue/chikungunya fever case within the past 2 weeks?** | **🗆 Yes 🗆 No if yes, when?**  **Where?** | |  |

1. **Vector Control Practices**

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| --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | **REMARKS** |
| **50** | **What is your water source** | **❑ Level 3 water system ❑ Deep well**  **❑ Well ❑ Spring**  **❑ Hauler (private) ❑ Hauler (public) ❑ Others\_\_\_\_\_\_\_\_\_\_** | |
| **51** | **Do you have stock water** | **🗆 Yes 🗆 No** |  |
|  | **Where do you store water?** | **❑ Drums ❑ Wash basins ❑ Water tank ❑ Pails**  **❑ water jug ❑ Plastic containers ❑ Others \_\_\_\_\_\_\_\_\_\_\_** |  |
| **52** | **Do you empty, clean and scrub container?** | **🗆 Yes 🗆 No If yes go to # 52** |  |
| **53** | **Number of times / week** |  |  |
|  | **Are your water containers covered?** | **🗆Yes 🗆 No** |  |

1. **PERSONAL PROTECTIVE MEASURES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | **REMARKS** |
| **54** | **DO YOU USUALLY WEAR LONG SLEEVES?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |
| **55** | **DO YOU USUALLY WEAR PANTS?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |
| **56** | **DO YOU APPLY INSECT REPELLANT?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |
| **57** | **DO YOU SPRAY INSECTICIDES AT HOME?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |
| **58** | **DO YOU USE ELECTRIC VAPORIZER AT HOME?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |
| **59** | **DO YOU USE UV BAITS?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |
| **60** | **IS YOUR ROOM WELL LIGHTED?** | **🗆 YES 🗆 NO** |  |
| **61** | **DO YOU USE MOSQUITO NETS DURING THE DAY?** | **🗆 YES 🗆 NO IF YES :❑ TREATED ❑ NON TREATED**  **❑ DAYTIME ❑ NIGHTTIME** |  |
| **62** | **ARE THE DOORS AND WINDOWS SCREENED?** | **🗆 YES 🗆 NO** |  |
| **63** | **DO YOU HAVE TREATED FOGGING ACTIVITIES?** | **🗆 YES 🗆 NO IF YES, HOW OFTEN\_\_\_\_\_\_\_\_\_\_\_** |  |

1. **ENVIRONMENTAL SANITATION AND PRACTICES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | **REMARKS** |
| **64** | **GARBAGE DISPOSAL** | **❑ COLLECTED ❑ BURNED ❑ BURIED/DUMPING ❑ THROWN ANYWHERE ❑ OTHERS IF COLLECTED, HOW MANY TIMES? \_\_\_\_\_/WK BY WHO? \_\_\_\_** | |
| **65** | **SEGREGATE GARBAGE?** | **🗆 YES 🗆 NO** | |
| **66** | **OWN TOILET** | **🗆 YES 🗆 NO IF NO, HOW DO YOU DISPOSE YOUR EXCRETA?** | |
| **67** | **TYPE OF TOILET** | **❑ POUR FLUSH ❑ COMMUNAL ❑ PIT PRIVY ❑ OTHERS\_\_\_\_\_\_\_\_** | |

1. **BREEDING SITES THAT CAN BE FOUND IN HOUSE, SCHOOL, WORKPLACE**

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| --- | --- | --- | --- |
| **Q#** | **QUESTION** | **ANSWER** | **REMARKS** |
| **68** | **DO YOU HAVE THE FOLLOWING** | **❑ WATER STORAGE/CISTERN ❑ DRUMS ❑ FLOWER VASE WITH WATER ❑ PLOTTED PLANTS WITH WATER ❑ ROOF GUTTER ❑ ANIMAL WATER CONTAINER ❑ HOLLOW FENCE POST ❑ USED TIRES ❑ DISCARDED LARGE APPLIANCES**  **❑ DISCARDED BUCKET/BOTTLES ❑ WATER CATCHER FOR PLATES/UTENSIL STORAGE ❑ TREE HOLE ❑ ROCK HOLES**  **❑ STAGNANT CANALS ❑ RICE FIELDS WITH STAGNANT CLEAN WATER ❑ OTHERS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **69** | **IS THERE A BODY OF WATER NEAR THE HOUSE?** | **🗆 YES 🗆 NO** |  |
| **70** | **IF YES, TYPE OF BODY OF WATER** | **❑ PONDS ❑ LAKES ❑ SPRINGS ❑ LAGOON ❑ POOL ❑ RIVER ❑ STREAM ❑ IRRIGATION CANAL**  **❑ CLEAN STAGNANT ❑ OTHERS \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

**Thank you**

|  |  |  |  |  |  |  |
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| **September 2016** | | | | | | |
| **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
|  |  |  |  | **1** | **2** | 3 |
| 4 | **5** | **6** | **7** | **8** | **9** | 10 |
| 11 | **12** | **13** | **14** | **15** | **16** | 17 |
| 18 | **19** | **20** | **21** | **22** | **23** | 24 |
| 25 | **26** | **27** | **28** | **29** | **30** |  |
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| **October 2016** | | | | | | |
| **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
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| 2 | **3** | **4** | **5** | **6** | **7** | 8 |
| 9 | **10** | **11** | **12** | **13** | **14** | 15 |
| 16 | **17** | **18** | **19** | **20** | **21** | 22 |
| 23 | **24** | **25** | **26** | **27** | **28** | 29 |
| 30 | **31** |  |  |  |  |  |