Meningococcal Disease Case Questionnaire

Patient name (Last, First):	**State ID:**
Patient Date of Birth:	**Address:**
Current Sex: ☐ M ☐ F	**Phone:**
Race: ☐ Alaska Native or American Indian ☐ White ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown (U)	**Ethnicity:** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Reporting Hospital:	**Physician:**	
Source: ☐ Blood ☐ CSF ☐ Other (specify): _____ **Date/time of collection:** _____ **Date/time of antibiotic administration:** _____	**Isolate sent to CDC-AIP for Serotyping?** **If Yes, Date:** _____	
Outcome: ☐ Survived ☐ Died ☐ Unknown	**Symptoms:**	
Outbreak/cluster related: ☐ Y ☐ N ☐ U	Headache ☐ Y ☐ N ☐ U	Fever ☐ Y ☐ N ☐ U
Homeless: ☐ Y ☐ N ☐ U	Stiff neck ☐ Y ☐ N ☐ U	Rash ☐ Y ☐ N ☐ U
College Student: ☐ Y ☐ N ☐ U	Photophobia ☐ Y ☐ N ☐ U	Nausea ☐ Y ☐ N ☐ U
HIV Status: ☐ Positive ☐ Negative ☐ U	Vomiting ☐ Y ☐ N ☐ U	Diarrhea ☐ Y ☐ N ☐ U
Is the patient taking eculizumab/Soliris? ☐ Y ☐ N ☐ U	Other (specify):	

Did the patient receive quadrivalent meningococcal vaccine (MCV4)? ☐ Y ☐ N ☐ U
Did the patient receive serogroup B meningococcal vaccine? ☐ Y ☐ N ☐ U
If yes to either, please complete the table below for each dose

Vaccine	Date Given	Lot Number

Epidemiologic Information

Does the patient attend day care*? ☐ Y ☐ N ☐ U
If yes, specify name of facility, location, and phone number (if available): _____
*Defined as a supervised group of 2 or more unrelated children for at least 4 hours per week

Does the patient reside in a congregate or long-term care facility? ☐ Y ☐ N ☐ U
If yes, specify name of facility, location, and phone number (if available): _____

Has the patient had recent travel history? ☐ Y ☐ N ☐ U
If yes, specify location and date(s): _____

Has the patient had recent contact with any visitors from another village/city/state? ☐ Y ☐ N ☐ U
If yes, specify location and date(s): _____

Household and close contacts[1] (provide information on any additional contacts on a separate sheet)

Name	DOB	Relationship to case	Household Member? *(Y, N)*	Meningococcal Vaccination History *(Vaccine type and dates)*	Prophylaxis Recommended? *(Y, N)*	Prophylaxis Provided? *(Y, N, U and date if Y)*

[1]Household or close contacts are defined as people residing with the index patient or nonresidents who spent 4 or more hours with the index patient for at least 5 of the 7 days preceding the day of hospital admission of the index case.

MSM (men who have sex with men) – complete these variables for any male cases 16 years of age and older.					
During the past 12 months, have you had sex with only males, only females, or with both males and females?			**Do you consider yourself to be:**		
☐ Males only	☐ Females only	☐ Both males and females	☐ Heterosexual/Straight	☐ Homosexual/Gay	☐ Bisexual
☐ Not sexually active	☐ Unknown	☐ Refused	☐ Other	☐ Unknown	☐ Refused

MSM not otherwise specified: ☐ Y ☐ N ☐ U

- Select Yes for this variable if MSM is noted somewhere (e.g. in hospital chart), but it is not known whether this was determined based on sexual behavior or sexual identity.
- Select No for this variable if this person is known to not be MSM.
- Select Unknown for this variable if MSM status is unknown.

Unprotected Health Care Personnel (exposure to case's respiratory sections e.g. intubation, suctioning, mouth-to-mouth resuscitation):

Completed by: _____ Phone: _____ Date: _____