

**TRICHINOSIS SURVEILLANCE CASE REPORT**

Form Approved  
OMB NO. 0920-0009

**PERSONAL DATA**

|   |  |                                       |  |  |
|---|--|---------------------------------------|--|--|
| <b>State Reporting:</b><br><br>State abbreviation _____   | <b>First four letters of last name:</b><br><br>_____ | <b>Age:</b><br><br>_____              | <b>Sex:</b><br><br><input type="checkbox"/> <b>Male</b> <input type="checkbox"/> <b>Female</b> | <b>Date of birth:</b><br><br>_____ Mo    _____ Day    _____ Yr |
| <b>Race/Ethnicity:</b><br><br><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown<br><input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White |  |                                       |  |  |
| <b>County:</b><br><br>_____   |  | <b>Physician's Name:</b><br><br>_____ |  | <b>Physician's Phone:</b><br><br>_____                         |

**DIAGNOSTIC DATA**

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <b>DATE OF ONSET OF ILLNESS:</b><br><br>_____ Mo    _____ Day    _____ Yr   |  | <b>OUTCOME:</b><br><br><input type="checkbox"/> Recovered <input type="checkbox"/> Died <input type="checkbox"/> Unknown                        |  |   |  |
| <b>SIGNS AND SYMPTOMS:</b><br><b>Eosinophilia:</b><br><br><input type="checkbox"/> Yes <input type="checkbox"/> Not Done<br><input type="checkbox"/> No <input type="checkbox"/> Unknown<br>Specify absolute number or percentage:<br>(#) _____ or (%) _____  |  | <b>Fever:</b><br><br><input type="checkbox"/> Yes <input type="checkbox"/> Unknown<br><input type="checkbox"/> No<br>Specify temperature: _____ |  | <b>Periorbital edema:</b><br><br><input type="checkbox"/> Yes <input type="checkbox"/> Unknown<br><input type="checkbox"/> No |  |
| <b>Myalgia:</b><br><br><input type="checkbox"/> Yes <input type="checkbox"/> Unknown<br><input type="checkbox"/> No   |  | <b>MUSCLE BIOPSY:</b><br><br><input type="checkbox"/> Positive<br><input type="checkbox"/> Negative<br><input type="checkbox"/> Not Done        |  |   |  |
| <b>SEROLOGIC FINDINGS:</b><br><br>Positive      Negative      Not Done      Unknown<br>Test type (specify): _____<br><br>Date of test: _____ Mo    _____ Day    _____ Yr      Test results:    Positive      Negative      Unequivocal      Unknown<br><br>Date of test: _____ Mo    _____ Day    _____ Yr      Test results:    Positive      Negative      Unequivocal      Unknown |  |   |  |   |  |

**EPIDEMIOLOGIC DATA**

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>SUSPECT FOOD:</b><br><br>Pork (specify type below):<br>Store bought pork<br>Pork from farm-raised pig<br>Wild boar<br>Other (specify): _____<br>Not specified  |  | <b>Non Pork (specify type below):</b><br>Bear meat<br>Hamburger (ground meat)<br>Other (specify): _____<br>Not specified  |  | <b>Unknown</b>   |  | <b>DATE CONSUMED:</b><br><br>_____ Mo    _____ Day    _____ Yr |  |
| <b>WHERE MEAT OBTAINED:</b><br><br>Supermarket/grocery store<br>Butcher shop<br>Restaurant or other public eating establishment<br>Direct from farm<br>Hunted or trapped<br>Other (specify): _____<br>Unknown |  | <b>PREPARATION AFTER PURCHASE FURTHER PROCESSING:</b><br><br>No further processing<br>Ground (i.e., hamburger)<br>Smoked<br>Dried jerky<br>Marinated<br>Other (specify): _____<br>Unknown |  |  | <b>METHOD OF COOKING:</b><br><br>Uncooked<br>Fried<br>Open-fire roasting/BBQ<br>Other cooking method (specify): _____<br>Unknown |  |  |
| <b>PATIENT'S OCCUPATION:</b><br><br>_____   |  |   |  | <b>RELATED CASES:</b><br><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |

**COMMENTS AND ADDITIONAL DATA**

Investigator name and title: \_\_\_\_\_

Date form completed: \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).