

# West Nile Virus Case History Form

California Department of Health Services  
Viral and Rickettsial Disease Laboratory  
850 Marina Bay Parkway  
Richmond, CA 94804

**Patient Information:**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_ **Medical Rec #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Phone:** Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Sex:**  Male **Ethnicity:**  Hispanic **Race:**  White  Asian/ Pacific Islander  
 Female  Non-Hispanic  Black  American Indian/Alaskan Native  
 Unknown  Unknown  Unknown  Other: \_\_\_\_\_

**Physician Information (Mandatory):**

**Name:** \_\_\_\_\_ **Facility:** \_\_\_\_\_  
**Pager/Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Date of first symptom(s):** \_\_\_/\_\_\_/\_\_\_  Hospitalized or  ER / Outpatient

**If hospitalized, admit date:** \_\_\_/\_\_\_/\_\_\_ **Discharge date:** \_\_\_/\_\_\_/\_\_\_ **If patient died, date of death:** \_\_\_/\_\_\_/\_\_\_

**Clinical syndrome:**

Encephalitis .....  Yes  No  Unk  
Aseptic meningitis .....  Yes  No  Unk  
Acute flaccid paralysis ....  Yes  No  Unk  
Febrile illness .....  Yes  No  Unk  
Asymptomatic .....  Yes  No  Unk  
Other \_\_\_\_\_

**Do the following apply anytime during current illness:**

In ICU .....  Yes  No  Unk  
Fever ≥38° .....  Yes  No  Unk  
Headache .....  Yes  No  Unk  
Rash .....  Yes  No  Unk  
Stiff neck .....  Yes  No  Unk  
Muscle pain/weakness ....  Yes  No  Unk  
Altered consciousness ....  Yes  No  Unk  
Seizures .....  Yes  No  Unk

CSF Results	CBC Results
Date: ___/___/___	Date: ___/___/___
RBC: _____	WBC: _____
WBC: _____	%Diff: _____
%Diff: _____	HCT: _____
Protein: _____	Plt: _____
Glucose: _____	

**Other lab results (MRI/CT, LFTs, etc.):** \_\_\_\_\_

**Past medical history:**

Hypertension:  Yes  No  Unk  
Diabetes Type \_\_\_\_\_  Yes  No  Unk  
Other: \_\_\_\_\_

**Exposures/Travel within 4 wks of onset (specify details):**

Mosquito bites/exposure:  Yes  No  Unk  
Traveled outside of California:  Yes  No  Unk  
Traveled outside the U.S.:  Yes  No  Unk  
Ever traveled outside the U.S.:  Yes  No  Unk

**Other pertinent information (specify details):**

Immunocompromised patient:  Yes  No  Unk  
Yellow fever vaccination:  Yes  No  Unk  
Date: \_\_\_/\_\_\_/\_\_\_  
Donated blood:  Yes  No  Unk  
Date: \_\_\_/\_\_\_/\_\_\_  
Donated organ:  Yes  No  Unk  
Date: \_\_\_/\_\_\_/\_\_\_  
Received blood:  Yes  No  Unk  
Date: \_\_\_/\_\_\_/\_\_\_  
Received organ:  Yes  No  Unk  
Date: \_\_\_/\_\_\_/\_\_\_  
Current pregnancy:  Yes  No  Unk  
Week of gestation: \_\_\_\_\_  
If infant, breast fed?  Yes  No  Unk

**Knowledge of WNV prior to illness:**

Did patient do anything to avoid mosquito bites?  Yes  No  Unk  
*If yes,*  
- used insect repellent?  Yes  No  Unk  
- drained standing water near home?  Yes  No  Unk

**Other significant history (social, family, etc.):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For questions regarding testing or specimens, call Cynthia Jean (510) 307-8606**  
Fax this form to (510) 307-8599 or mail to CDHS VRDL – West Nile Virus, 850 Marina Bay Parkway, Richmond CA 94804