DATE OF REPORT
Month Day Year

FORM APPROVED
OMB NO. 0920-0008

CDC CASE REPORT NUMBER

CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES
INFECTIOUS DISEASE SECTION
2151 Berkeley Way, Rm.715
Berkeley, CA 94704

STATUS OF THIS REPORT
☐ New case ☐ Update report

STATE/LOCAL CASE REPORT NUMBER

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) CASE REPORT

I. BASIC PATIENT INFORMATION

PATIENT'S NAME _____ (Last) _____ (First) _____ (Middle) _____ (Maiden/Other)

DATE OF BIRTH (Month Day Year)

AGE AT DIAGNOSIS AIDS (Years)

SEX
☐ Male
☐ Female

RACE/ETHNIC ORIGIN
☐ White ☐ Asian/Pacific Islander
☐ Black ☐ American Indian/Alaskan Native

Is patient of Hispanic (Latin American) origin? ☐ Yes ☐ No

RESIDENCE AT ONSET OF ILLNESS SUGGESTIVE OF AIDS

_____ (City) _____ (County) _____ (State/(Country)) Zip Code

CDC USE
City
County
State

CURRENT CONDITION/PROGNOSIS
☐ Outpatient/ambulatory
☐ Hospitalized, not critical
☐ Hospitalized, critical
☐ Dead

IF DEAD, DATE OF DEATH (Month Day Year)

AUTOPSY PERFORMED?
☐ Yes ☐ No

II. SPECIFIC CONDITIONS AND OPPORTUNISTIC INFECTIONS MOST FREQUENTLY ASSOCIATED WITH AIDS

Has the patient had any of the conditions/opportunistic infections listed below most frequently associated with AIDS? Check all that apply, indicate anatomic site if appropriate, and give date of diagnosis or specimen collection and the most specific or reliable method of diagnosis used (write in code number from list at bottom of page).

	DATE OF SPECIMEN OR DIAGNOSIS Month	Year	METHOD OF† DIAGNOSIS
☐ Kaposi's Sarcoma (check all anatomical sites that apply) ☐ Lymph Nodes ☐ Mouth/Pharynx ☐ Skin ☐ Anus/Rectum ☐ Internal Organs* ☐ Other* *Specify site _____			
☐ Pneumocystis carinii pneumonia			
☐ Toxoplasmosis, encephalitis or brain abscess			
☐ Atypical (non-tuberculous) Mycobacterial infection (severe/ disseminated, e.g. bone marrow or multiple organ involvement) ☐ M. avium-intracellulare ☐ Other species* *Specify species _____			
☐ Candida esophagitis (Candida infections at others sites may be reported on Page 2)			
☐ Cryptosporidiosis with chronic diarrhea (persisting ≥ 1 month)			
☐ Cytomegalovirus infection* (symptomatic, disseminated, esperially with documented pathology of lungs, intestine; exclude mononucleosis syndrome) *Specify site(s) _____			
☐ Cryptococcal infection: ☐ Meningitis ☐ Other* *Specify site(s) _____			
Progressive multifocal leukoencephalopathy (Papovavirus infection, brain)			

Species
Sites
Sites
Sites

OTHER OPPORTUNISTIC INFECTIONS AND CANCERS THAT MAY BE ASSOCIATED WITH AIDS ARE LISTED ON THE NEXT PAGE.

†METHODS OF DIAGNOSIS: (Not all methods are appropriate or acceptable for all diseases)
1 = Microscopy: cytology, histology
2 = Culture/microbiologic techniques
3 = Endoscopy: bronchoscopy, sigmoidoscopy, etc.
4 = Serology: Antibody titer
5 = Antigen detection, any technique
6 = Physical examination
7 = X-ray, fluoroscopy, etc.
8 = Ultrasound, CAT scan, etc.
9 = Unknown

OTHER OPPORTUNISTIC INFECTIONS AND CANCERS, some of which are listed below, have also been reported in patients with AIDS, although a single infection of this type usually is not specific for AIDS. In the following spaces, list these or other diseases the patient has had, the site of occurrence, the date of diagnosis or specimen collection, and the most specific or reliable method of diagnosis used (use code number from list below).

- o Herpes simplex infection, chronic or progressive mucocutaneous ulceration lasting ≥ 1 month
- o Tuberculosis, especially severe or disseminated (e.g., involving liver, marrow)
- o Nocardia infection (Nocardiosis)
- o Coccidioides infection (Coccidioidomycosis)
- o Lymphoma or reticulum cell sarcoma involving the brain only
- o Burkitt's lymphoma
- o Diffuse, pleomorphic, undifferentiated, non-Hodgkin's lymphoma

PATHOGEN/DISEASE	ANATOMIC SITE	DATE OF SPECIMEN OR DIAGNOSIS Month	DATE OF SPECIMEN OR DIAGNOSIS Year	METHOD OF† DIAGNOSIS	CDC USE Pathogen/ Disease	CDC USE Anatomic Site
		☐☐	☐☐	☐	☐☐	☐☐
		☐☐	☐☐	☐	☐☐	☐☐
		☐☐	☐☐	☐	☐☐	☐☐

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III. INFECTIONS/CONDITIONS OCCURRING WITH BUT NOT SPECIFIC FOR AIDS OR AIDS PRODROME

Check all that have occurred: ☐None ☐Unknown

- ☐ Amebiasis, persistent
- ☐ Herpes simplex, chronic or persistent vesicular infection
  - ☐Mouth/Pharynx ☐Genital ☐Anal/Rectal ☐Other
- ☐ Herpes zoster
  - ☐Localized ☐Disseminated
- ☐ Candida infection
  - ☐Colo/Rectal ☐Oral/Pharyngeal (thrush)
- ☐ Idiopathic/Autoimmune thrombocytopenic purpura
- ☐ Autoimmune hemolytic anemia
- ☐ Nephrotic syndrome
- ☐ Other (Specify)_____

IV. SIGNS/SYMPTOMS PRODROMAL TO AIDS

Check all signs/symptoms persistent at least one month before onset of a specific infection/disease suggestive of AIDS. ☐None ☐Unknown

Approximate Date Onset First Sign/Symptom: Month ☐☐ Year ☐☐

- ☐ Fever
- ☐ Night sweats
- ☐ Malaise/Fatigue
- ☐ Chronic lymphadenopathy, ≥ 3 non-contiguous sites
- ☐ Arthralgias/Myalgias
- ☐ Weight loss, unexpected, > 15 pounds or ≥ 10% normal body weight
- ☐ Chronic diarrhea
  - ☐No pathogen/cause identified
  - ☐Specific pathogen/cause identified (Specify)_____
- ☐ Persistent bone marrow dysfunction
  - ☐Leukopenia (<4300/mm^3) ☐Lymphopenia (<1500/mm^3)
  - ☐Thrombocytopenia (<100,000/mm^3)
- ☐ Other (Specify)_____

V. DISEASES OR CONDITIONS PRECEDING OR COEXISTING WITH DIAGNOSIS OF AIDS

Check all that have occurred: ☐None ☐Unknown

- ☐ Leukemia
  - ☐Acute lymphocytic ☐Chronic lymphocytic ☐Non-lymphocytic
- ☐ Hodgkin's disease
- ☐ Non-Hodgkin's lymphoma
- ☐ Multiple myeloma
- ☐ Diabetes mellitis, insulin-dependent
- ☐ Renal failure, chronic
- ☐ Hepatitis, chronic
- ☐ Congenital immune deficiency syndrome (specify)_____
- ☐ Bleeding disorder/Clotting factor deficiency
  - ☐Factor VIII deficiency (classical Hemophilia)
  - ☐Factor IX deficiency
  - ☐Other requiring factor replacement therapy (specify)_____
- ☐ Other (specify)

VI. MEDICAL IMMUNOSUPPRESSIVE THERAPY ☐ None ☐ Unknown

During 3 months preceding diagnosis of AIDS, did patient receive (check all that apply):

☐ Systemic corticosteroids ☐ Cytotoxic chemotherapy/other immunosuppressive therapy

If yes, did symptoms of specific infectious disease precede immunosuppressive therapy? ☐ Yes ☐ No

CDC USE

VII. SOCIAL AND RISK FACTORS (Check all that apply)

Usual occupation(s) of patient during last 5 years _____

Marital Status: ☐ Never married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown

Living arrangement of patient during year preceding diagnosis of AIDS:
☐ Alone ☐ With spouse ☐ With children ☐ With male companion(s) ☐ With female companion(s)

Was patient born in U.S. (50 states)? ☐ Yes ☐ No If no, date of arrival in U.S. Month ☐☐ Year ☐☐

If patient or either parent were born outside U.S., what was country/territory of birth/origin?
☐ Canada ☐ Cuba ☐ Dominican Republic ☐ Haiti ☐ Mexico ☐ Puerto Rico

☐ Cambodia/Vietnam/Laos ☐ Other (specify country/territory) _____

Has the patient ever used needles for self-injection of non-prescription drugs? ☐ Yes ☐ No ☐ Unknown

What is the sexual orientation of this patient?
☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ None ☐ Unknown

Was the patient pregnant while ill with AIDS? ☐ Yes ☐ No ☐ Unknown ☐ Never Pregnant
Has the patient delivered a live-born infant during the last 5 years? ☐ Yes ☐ No ☐ Unknown

During the five years preceding diagnosis of possible AIDS, did this patient:

	Yes	No	Unknown		Yes	No	Unknown
o Have sexual relations with a male partner ?	☐	☐	☐	o Been in jail or served a prison term?	☐	☐	☐
o Have sexual relations with a female partner?	☐	☐	☐	o Receive Factor VIII concentrate?	☐	☐	☐
o Have sexual relations with a person who now has AIDS?	☐	☐	☐	o Receive cryoprecipitate?	☐	☐	☐
o Have close, non-sexual contact with a person who now has AIDS?	☐	☐	☐	o Receive Factor IX concentrate?	☐	☐	☐
o Receive hepatitis B vaccine?	☐	☐	☐	o Receive blood or packed red cell transfusion?	☐	☐	☐
o Receive hepatitis B immune globulin (HBIG)?	☐	☐	☐	o Receive other blood components, e.g., platelets, plasma, etc?	☐	☐	☐
o Receive other immune globulins?	☐	☐	☐	o Donate blood?	☐	☐	☐
o Undergo hemodialysis?	☐	☐	☐	o Donate plasma?	☐	☐	☐

If patient has donated blood or plasma, what is the name and address of the last or most frequently used donation center?

Approximate date of last donation Month ☐☐ Day ☐☐ Year ☐☐

_____ Name of blood/plasma center _____ City _____ State

VIII. LABORATORY DATA: Results before use of immunosuppressive therapy (cytotoxic drugs, steroids) preferred.

WHITE BLOOD CELL COUNT ☐☐☐☐☐

PERCENTAGE LYMPHOCYTES ☐☐.☐ %

PLATELET COUNT (Lowest value) ☐☐☐☐☐☐

Date of Laboratory Tests Month ☐☐ Day ☐☐ Year ☐☐

T-LYMPHOCYTE SUBSET COUNTS: Check if T-cell studies not performed

Check if patient received steroids/other immunosuppressive therapy during month before T-cell studies

Percentage of Lymphocytes
T-HELPER (OKT-4, Leu-3) ☐☐ %

Percentage of Lymphocytes
T-SUPPRESSOR (OKT-8, Leu-2) ☐☐ %

Date of T-Lymphocyte Tests Month ☐☐ Day ☐☐ Year ☐☐

T-HELPER/T-SUPPRESSOR (T_H/T_S) RATIO ☐.☐☐

Interpretation of T_H/T_S ratio for this patient is: ☐ Normal ☐ High ☐ Low

Range of normal values for T_H/T_S ratio at this laboratory: High normal ☐.☐ Low normal ☐.☐

ADDITIONAL INFORMATION OR COMMENTS:

IX. HOSPITALIZATION: Where is/has patient been hospitalized most recently for diagnosis or treatment of disease associated with AIDS or cellular immune deficiency conditions?

☐ CHECK IF NEVER HOSPITALIZED

Hospital ______ Address ______

MEDICAL RECORD NUMBER ☐☐☐☐☐☐☐☐☐

ADMISSION DATE ☐☐ Month ☐☐ Day ☐☐ Year

City State

* *

1. Name of person completing this form ______ Telephone ( ) Ext

Title/Position/Specialty ______

Institution/Address ______

2. Person reporting this case (if different from above) ______ Telephone ( ) Ext

Title/Position/Specialty ______

Institution/Address ______

Physician to contact to update information about this patient (if different from above):

3. Name: ______ Telephone ( ) Ext

Title/Position/Specialty ______

Institution/Address ______

Other physicians who may provide important information about this patient:

4. Name: ______ Telephone ( ) Ext

Title/Position/Specialty ______

Institution/Address ______

5. Name: ______ Telephone ( ) Ext

Title/Position/Specialty ______

Institution/Address ______

* *

FOR CDC USE

Place of diagnosis resulting in initial case report:

Hospital ☐☐☐ City ☐☐ State ☐☐

Form reviewer ☐☐

Date of form review ☐☐ Month ☐☐ Day ☐☐ Year

Case Classification ☐ ☐

Date of keypunch/ computer entry