Ascariasis Investigation Form | **NBS Patient ID:**

Patient's name: ____
Last First MI
Address: ____
City: ______________ **County:** ______________ **Zip:**________
Phone 1: ( ) __________ **Phone 2:** ( ) ______________
Date of birth: ____/____/____ **Age:** ____**Sex:** ☐Male ☐Female ☐Unk
Race: ☐White ☐Black ☐Asian ☐Pacific Islander
☐Native American/Alaskan ☐Unknown ☐ Other: ______________
Hispanic: ☐ Yes ☐ No ☐ Unknown
Patient Occupation:________________________________
Parent/guardian's name______________________________
Country of origin:____________ **Date of arrival in US:** ___/___/___

Reported by: ________________________________
Agency: ________________________________
Phone: ( )____________**Date reported:** ____/____/____

Investigated by: ________________________________
Agency: ________________________________
Phone: ( ) ______________
Email:________________________________
Investigation start date: ____/____/____

CLINICAL DATA

Date of symptom onset: ___/___/___ **Illness end date**: ___/___/___ **Did patient die?** ☐ Yes, date of death: ___/___/___ ☐ No ☐ Unk

Signs and symptoms (Check all that apply):

☐ Indigestion ☐ Coughing/Wheezing ☐ Loss of Appetite ☐ Weight Loss ☐ Abdominal Pain ☐ Vomiting ☐ Fatigue
☐ Intestinal Obstruction/Bolus ☐ Other: ________________________________

Did the patient receive treatment? ☐ Yes ☐ No ☐ Unk Treatment start date: ___/___/___

If yes: ☐ Albendazole ☐ Mebendazole ☐ Ivermectin ☐ Other ________________________________

Physician's name: ________________________________ **Physician's phone:** ( ) ______________________

Was the patient hospitalized? ☐ Yes, name of hospital: ______________________________ ☐ No ☐ Unknown

If yes, Date of admission: ____/____/____ Date of discharge: ____/____/_____

LABORATORY

☐ Microscopic identification of eggs in feces (O&P). Collection date: _____/_____/_____
☐ Microscopic identification of *Ascaris* larvae from sputum or gastric washings. Collection date: _____/_____/_____
☐ Identification of adult worms passed from the nose, mouth, or anus. Collection date: _____/_____/_____
☐ Diagnostic imaging showing the presence of worms. Date image taken: _____/_____/_____

CONTACTS

How many people live in the patient's household? ________

Has anyone else in the household been treated for a helminthitic/parasitic infection? ☐ Yes ☐ No ☐ Unk

If yes, what type of infection? ____

Are there any contacts ill with similar illness? ☐ Yes (If yes, list below.) ☐ No ☐ Unk

Last name: ______________________ First/ MI______________________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: __________________ Onset date: _______ Type of infection/symptoms: ________________________
____
Contact info same as case? ☐ Yes ☐ No Address: ________________________________ Phone: ( )____________

Last name: ______________________ First/ MI______________________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: __________________ Onset date: _______ Type of infection/symptoms: ________________________
____
Contact info same as case? ☐ Yes ☐ No Address: ________________________________ Phone: ( )____________

Last name: ______________________ First/ MI______________________ Age: ________ **Sex:** ☐Male ☐Female ☐Unk
Relationship to case: __________________ Onset date: _______ Type of infection/symptoms: ________________________
____
Contact info same as case? ☐ Yes ☐ No Address: ________________________________ Phone: ( )____________

Ascariasis Investigation Form Continued	**NBS Patient ID:**

EXPOSURE HISTORY

Has the patient or any member of the household lived or traveled internationally in the last 2 years? ☐ Yes ☐ No ☐ Unknown

If yes, where and when?

Country Visited	**Dates Traveled**	**Traveler**
		☐ Patient ☐ Household member
		☐ Patient ☐ Household member
		☐ Patient ☐ Household member
		☐ Patient ☐ Household member

Does the patient visit, work, or live on a farm? ☐ Yes ☐ No ☐ Unknown

If yes, where? _____

Does the patient have contact with soil (e.g. gardening, landscaping, child playing outside in dirt) either for work or recreation?

☐ Yes ☐ No ☐ Unknown If yes, describe: _____

_____

What type of plumbing system exists in the patient's home?

☐ City sewage disposal ☐ Septic Tank ☐ Other, please describe: _____

_____

Near the patient's home, work, or school are there areas potentially contaminated with human waste (e.g. outhouses, contaminated bodies of water)? ☐ Yes ☐ No ☐ Unknown

If Yes, please describe: _____

_____

_____

COMMENTS