



Brucellosis Case Investigation

NBS Patient ID: \_\_\_\_\_

PLEASE PRINT LEGIBLY

Confirmed Probable Not a Case

Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: Male Female Unknown
Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_
Patient Phone: \_\_\_\_\_ County of Residence: \_\_\_\_\_
Race: Asian American Indian/Alaskan Native
Black or African American Native Hawaiian/Pacific Islander
White Unknown Other: \_\_\_\_\_
Ethnicity: Hispanic Not Hispanic Unknown

Clinical Information

Physician: \_\_\_\_\_ Address: \_\_\_\_\_
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
Was the patient hospitalized for this illness? Yes No Unknown
If yes, provide name and location of hospital: \_\_\_\_\_
Dates of hospitalization: Admission \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge \_\_\_\_/\_\_\_\_/\_\_\_\_
Date of illness onset: \_\_\_\_/\_\_\_\_/\_\_\_\_
Was the patient pregnant during illness? Yes No Unknown N/A
Is the patient deceased? Yes No Unknown
If yes, provide date of death: \_\_\_\_\_ (submit documentation)

Clinical Evidence

Fever Yes No Unknown Endocarditis Yes No Unknown
Night sweats Yes No Unknown Orchitis Yes No Unknown
Arthralgia Yes No Unknown Epididymitis Yes No Unknown
Headache Yes No Unknown Hepatomegaly Yes No Unknown
Fatigue Yes No Unknown Splenomegaly Yes No Unknown
Anorexia Yes No Unknown Arthritis Yes No Unknown
Myalgia Yes No Unknown Meningitis Yes No Unknown
Weight loss Yes No Unknown Spondylitis Yes No Unknown

Other pertinent clinical history:

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**Laboratory Findings**

**If culture-positive, did any possible laboratory exposures occur?**       Yes    No    Unknown  
*If yes, use the Brucellosis Laboratory Exposure Questionnaire on the DSHS Website to assess risk and make recommendations for testing and PEP.*

Serologic Tests		Date Collected	Titer/Value	Interpretation
Agglutination Test (Acute)				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
Agglutination Test (Convalescent)				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
Other				
Other Tests	Species Identified	Date Collected	Source	Interpretation
PCR				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done
Culture				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done

**Risk Factors**

**In the last 10 years, did the case:**

Live or travel in another region of the United States?       Yes    No    Unknown  
 If yes, where: \_\_\_\_\_      Year: \_\_\_\_\_

Live or travel outside of the United States?       Yes    No    Unknown  
 If yes, where: \_\_\_\_\_      Year: \_\_\_\_\_

Have contact with animals (e.g., dogs, cows, goats, pigs, etc.)?       Yes    No    Unknown

Animal Type	Year	Location	Description

Hunt and/or field dress an animal in the United States or abroad?       Yes    No    Unknown

Animal Type	Year	Location	Was PPE used? (Y/N)	Additional Details

Consume unpasteurized dairy products or undercooked meat?       Yes    No    Unknown

Product Description	Year	Where Purchased	Additional Details

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**Risk Factors (continued)**

Have contacts with similar symptoms or were diagnosed with brucellosis?  Yes  No  Unknown

If yes, provide details: \_\_\_\_\_

Have an occupational exposure (e.g., laboratorian, veterinarian, abattoir worker)?  Yes  No  Unknown

If yes, describe the exposure \_\_\_\_\_

Was post-exposure prophylaxis administered?  Yes  No  Unknown

In the **30 days** prior to illness onset, did the patient donate blood products, organs, or tissues?  Yes  No  Unknown

Type of Donation	Date(s)	Location	Additional Details

**Treatment**

Did the patient receive antibiotic treatment?  Yes  No  Unknown

If yes, select all that apply:

Doxycycline

Streptomycin

Rifampin

Unknown

Other (specify): \_\_\_\_\_

Combined duration of antibiotics for this illness:  <1 month  1-3 months  >3 months  unknown

**Comments or Other Pertinent Epidemiological Data (Use separate page if necessary)**

**Notes**

Date First Reported: \_\_\_\_/\_\_\_\_/\_\_\_\_ Investigation: Started \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed \_\_\_\_/\_\_\_\_/\_\_\_\_

Reporting Facility: \_\_\_\_\_

Name of Investigator: \_\_\_\_\_ (Please print clearly)

Agency: \_\_\_\_\_ (Please do not abbreviate)

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_