TEXAS Health and Human Services | Texas Department of State Health Services

Mpox Case Investigation Form
Patient Under Investigation (PUI) Short Form

Local health departments should submit this report to the regional health department.
Regional health departments should email this report to EAIDUMonitoring@dshs.texas.gov

Patient's Name:	Address:	City:	County:	State:
Date of Birth:	Home Phone:	Cell Phone:	Email:	

Date of Report:	City:	County:	State:
Investigator's name:	Phone:	Email:	Investigation Start Date:
Physician's name:	Phone/Pager:		
Reporter's name:	Phone:	Email:	

PATIENT INFORMATION

Sex: ¯ M ¯ F **Age**: _____ ¯ yr ¯ mo **Residency:** ¯ US resident ¯ Non-US resident, country: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Native American/Alaskan ☐ Unknown ☐ Other: _____

Hispanic: ☐ Yes ☐ No ☐ Unknown

Patient's Occupation: _____

What is the patient's current living situation? ☐ House ☐ Apartment ☐ Dormitory ☐ Congregate Setting

☐ Long-term Care Facility ☐ Hospital ☐ Homeless ☐ Unknown ☐ Other: _____

Does the patient have any known immunocompromising conditions or take immunosuppressive medications? ☐ Yes ☐ No ☐ Unknown

If Yes, what condition(s): _____

Has the patient received a smallpox vaccine? ☐ Yes ☐ No ☐ Unknown Date of Vaccination: ____/____/_____

CLINICAL PRESENTATION

Date of symptom onset: ____/____/_____ **Is the patient hospitalized?** ☐ Yes ☐ No ☐ Unknown **Facility Name:** _____

Symptoms (*mark all that apply*): ☐ Fever **Highest Temperature:** _____°F

☐ Rash ☐ Enlarged Lymph Nodes ☐ Cough ☐ Eye Lesions ☐ Conjunctivitis ☐ Pruritis (itching) ☐ Vomiting or Nausea

☐ Chills ☐ Malaise (general feeling of illness/weakness) ☐ Myalgia (muscle aches) ☐ Headache ☐ Tenesmus (urgency to defecate)

☐ Rectal Pain ☐ Rectal Bleeding ☐ Pus or Blood in Stool ☐ Other: _____

Date of rash onset: ____/____/_____ **Where did the rash first appear?** _____

At what site(s) is the rash currently located? ☐ Face ☐ Head ☐ Neck ☐ Mouth, Lips, or Oral Mucosa ☐ Trunk ☐ Arms ☐ Legs

☐ Palms of Hands ☐ Soles of Feet ☐ Genitals ☐ Perianal ☐ Other: _____

Distribution of lesions (mark one): ☐ Centrifugal (concentrated at the head and extremities) ☐ Centripetal (concentrated on the trunk)

When the rash was at its worst, approximately how many lesions were there on the body? ☐ 1-10 ☐ 10–50 ☐ 50-100 ☐ >100 ☐ Unknown

Current lesion development stage(s): ☐ Macules ☐ Papules ☐ Vesicles ☐ Pustules ☐ Scabs ☐ Other: _____

Are all lesions at the same stage? ☐ Yes ☐ No ☐ Unknown If not, describe: _____

Are all lesions on the same site of the body? ☐ Yes ☐ No ☐ Unknown

Are all lesions the same size? ☐ Yes ☐ No ☐ Unknown

If possible, please provide photos to help characterize the lesion development and distribution.

Are the lesions deep seated and profound (i.e., are the lesions deep in the skin)? ☐ Yes ☐ No ☐ Unknown

Are the lesions well-circumscribed (i.e., are the lesions well defined from the surrounding skin)? ☐ Yes ☐ No ☐ Unknown

Are the lesions umbilicated (i.e., are the centers of the lesions depressed like a navel)? ☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGICAL EXPOSURES

In the 21 days before symptom onset, did the patient (*mark all that apply*):

☐ **Have close contact with a known mpox case?**

If Yes, date(s) of contact with known mpox case: _____/_____/_____

☐ **Have contact with one or more persons with similar symptoms?**

If Yes, complete the table on page 3. Print extra pages, if necessary.

☐ **Have close contact with any exotic pets or animals?**

If Yes, date(s) of contact with animal(s): _____/_____/_____

If Yes, what type(s) of animals: ☐ Prairie Dog ☐ Rabbit ☐ Rope Squirrel ☐ Gambian Rat ☐ Wallaby ☐ African Tree Squirrel

☐ Other: _____

If Yes, what type of contact? ☐ Bite ☐ Petting/handling ☐ Other: _____

If Yes, did the animal appear sick? ☐ Yes ☐ No ☐ Unknown

☐ **Have any sexual encounters?**

If Yes, was the encounter(s) with: ☐ Any Male(s) ☐ Any Female(s) ☐ Any Non-binary Person(s)

If Yes, date(s) of sexual contact: _____/_____/_____

If Yes, briefly describe the nature of the encounter(s): _____

☐ **Have a history of travel?** ☐ Yes ☐ No ☐ Unknown

Destination (city, state, country)	Arrival Date	Departure Date	Reason for Travel	Mode of Travel	Travel Details (e.g., flight number, seat number)
	___/___/_____	___/___/_____			
	___/___/_____	___/___/_____			
	___/___/_____	___/___/_____			

ILL CONTACTS

Contact # _____

Name:	Gender:	Age:	Relationship:	Home Phone:	Cell Phone:
Date of First Contact with Patient:	**Diagnosis (if known):**		**Recent Travel?** ☐ Yes ☐ No ☐ Unknown	**Travel Details (if applicable)**	

What type of contact did the patient have with this contact?

☐ Caregiving ☐ Sexual Contact ☐ Shared Food, Utensils, or Dishes ☐ Shared Clothing ☐ Shared Towels or Bedding ☐ Shared Bathroom ☐ Unknown

☐ Face-to-Face Contact, specify length of time:____________ ☐ Transit Trip, specify length of time: ____________ ☐ Other: ______________________________

Contact # _____

Name:	Gender:	Age:	Relationship:	Home Phone:	Cell Phone:
Date of First Contact with Patient:	**Diagnosis (if known):**		**Recent Travel?** ☐ Yes ☐ No ☐ Unknown	**Travel Details (if applicable)**	

What type of contact did the patient have with this contact?

☐ Caregiving ☐ Sexual Contact ☐ Shared Food, Utensils, or Dishes ☐ Shared Clothing ☐ Shared Towels or Bedding ☐ Shared Bathroom ☐ Unknown

☐ Face-to-Face Contact, specify length of time:____________ ☐ Transit Trip, specify length of time: ____________ ☐ Other: ______________________________

Contact # _____

Name:	Gender:	Age:	Relationship:	Home Phone:	Cell Phone:
Date of First Contact with Patient:	**Diagnosis (if known):**		**Recent Travel?** ☐ Yes ☐ No ☐ Unknown	**Travel Details (if applicable)**	

What type of contact did the patient have with this contact?

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☐ Face-to-Face Contact, specify length of time:____________ ☐ Transit Trip, specify length of time: ____________ ☐ Other: ______________________________

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