Infectious Disease Control Unit, Texas Department of State Health Services
P.O. Box 149347, MC 1960
Austin, Texas 78714
Phone: (512) 776-7676 Fax: (512) 776-7616
VPDTexas@dshs.texas.gov

Mumps Case Track Record

FINAL STATUS:
☐ CONFIRMED
☐ PROBABLE
☐ SUSPECT
☐ RULED OUT /NOT A CASE

NBS PATIENT ID#: ______________________________

NBS INVESTIGATION ID#: ______________________________

Patient's Name: ______________________________ (last) ______________ (first)
Address: ____
City: ____________________ County: ______________ Zip: __________
Region: ________ Phone: ( ) ______________________________
Parent/Guardian: ____
Physician: ________________________ Phone: ( ) ____________
Address: ____
____
☐ Check box if history of homelessness in last 6 months
Occupation: ____

Reported by: __________________________________
Agency: ______________________________________
Phone: ( )____________
Date reported: ____/____/____
Investigated by: ______________________________
Agency: ______________________________________
Phone: ( ) ______________
Email:_______________________________________
Investigation start date: ____/____/____
Date investigation completed: ____/____/____

DEMOGRAPHICS: *DATE OF BIRTH:* _____/_____/_____ *AGE:* ________ *PLACE OF BIRTH*: ☐ USA ☐ Other:___________ ☐ Unknown
SEX: ☐ Male ☐ Female ☐ Unknown
RACE: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pac. Islander ☐ Am. Indian or Alaska Native ☐ Unknown
HISPANIC: ☐ Yes ☐ No ☐ Unknown
Did patient die? ☐ Yes, died on: ____/____/______ ☐ No, but still ill ☐ No, recovered ☐ Unknown
If female, is patient currently pregnant? ☐ Yes ☐ No ☐ Unknown Obstetrician's name, address, and phone #: ______________________
If yes, estimated date and location of delivery: ____/____/____ ____

CLINICAL DATA
Illness onset date: ____/____/____ **Illness end date**: ____/____/____ **First symptom reported:** ________________________
Parotitis - Onset Date: _____/_____/_____ Parotitis Duration: ______ Days Parotitis swelling: ☐ Right side☐ Left side ☐ Bilateral ☐Unknown

Fever? ☐Yes / ☐No If yes, onset date: ____/____/____
Headache? ☐Yes / ☐No If yes, onset date: ____/____/____
Loss of appetite? ☐Yes / ☐No If yes, onset date: ____/____/____
Myalgia? ☐Yes / ☐No If yes, onset date: ____/____/____
Malaise? ☐Yes / ☐No If yes, onset date: ____/____/____

Complications:
Meningitis ☐Yes / ☐No If yes, onset date: ____/____/____
Deafness ☐Yes / ☐No If yes, onset date: ____/____/____
Oophoritis ☐Yes / ☐No If yes, onset date: ____/____/____
Pancreatitis ☐Yes / ☐No If yes, onset date: ____/____/____
Encephalitis ☐Yes / ☐No If yes, onset date: ____/____/____
Orchitis ☐Yes / ☐No If yes, onset date: ____/____/____
Mastitis ☐Yes / ☐No If yes, onset date: ____/____/____
Other (specify):________________________, onset date: ____/____/____

Does the patient have pelvic inflammatory disease? ☐Yes / ☐No / ☐ Unknown

Was the patient hospitalized for this illness? ☐Yes / ☐No
Hospitalized at: ______________________________ Admitted: ____/____/____ Discharged: ____/____/____ Duration of Stay: ________days

LABORATORY DATA: Was laboratory testing done? ☐ Yes ☐ No ☐ Unknown

LABORATORY: Ordering Provider: ________________________________ Reporting Facility:________________________________

☐ PCR: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

Type of specimen: ☐ buccal swab ☐ urine ☐ other:___________________

☐ DSHS ☐ Other: ______________________________ Lab ID:____________________________

☐ PCR: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

Type of specimen: ☐ buccal swab ☐ urine ☐ other:___________________

☐ DSHS ☐ Other: ______________________________ Lab ID:____________________________

☐ IgM: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

☐ DSHS ☐ Other: ______________________________ Lab ID:____________________________

☐ IgG: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

Date convalescent collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

☐ Mumps Virus Isolated: Date specimen collected: ______/______/_____ Lab Report Date: _____/_____/_____

Type of specimen: ___________________________

☐ DSHS ☐ Other: ______________________________ Lab ID:____________________________

VACCINATION HISTORY: *CDC Objective: 90% of mumps cases must have a vaccination history captured.*

VACCINATED: ☐ Yes ☐ No ☐ Unknown

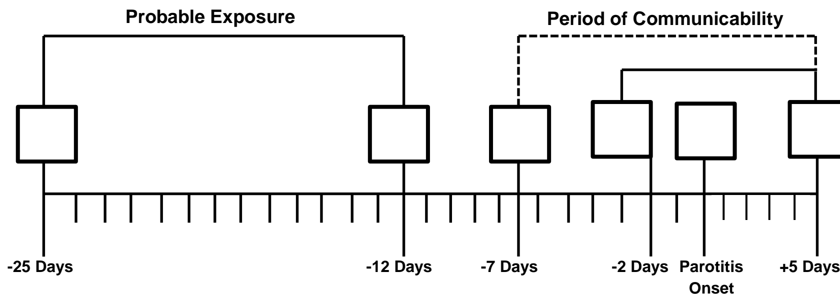
If yes, list dates: ☐ 1st MMR: _____/_____/_____ ☐ 2nd MMR: _____/_____/_____ ☐ 3rd MMR*: _____/_____/_____

If no, indicate reason: ☐ Born outside of U.S. ☐ Previous Disease - Lab Confirmed ☐ Previous Disease – MD Diagnosed ☐ Medical Contraindication ☐ Never offered vaccine ☐ Parent/Patient forgot ☐ Parental/Patient Refusal ☐ Parent/Patient report of disease ☐ Philosophical Objection ☐ Religious exemption ☐ Religious exemption ☐ Evidence of immunity ☐ Under Age ☐ Unknown ☐ Other: ___________________________

**If there is a 3rd MMR, was this due to a 3rd dose vaccination clinic? ☐Yes / ☐No If yes, which clinic? _________________*

INFECTION TIMELINE:

Enter onset of parotitis. Count backwards and forwards to enter dates for probable exposure and communicable periods.



SOURCE OF INFECTION: ☐ No exposure identified ☐ Close contact with a known or suspected case: ________________________

Where did this case acquire mumps?: ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr. Office ☐ Hospital ER ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐ International Travel ☐ Unknown ☐ Other: ___________________________

Did the case live in a congregate setting? ☐ Yes ☐ No ☐ Unknown

If yes, what setting? ☐ Apartment/shared housing ☐ College dorm ☐ Fraternity/sorority house ☐ Correctional Facility ☐ Immigration Detention Facility ☐ Other_______________________________

Has any travel occurred within the exposure period? ☐ Yes ☐ No ☐ Unknown If yes, list location: ______________________________

Importation Class*: ☐ Indigenous ☐ International ☐ Out-of-state ☐ Unknown If imported, from what country/state:_________________

Is case traceable within 2 generations to international import? ☐ Yes ☐ No ☐ Unknown

Is case part of an outbreak? ☐ Yes ☐ No ☐ Unknown If yes, list outbreak name: ____

*http://wwwn.cdc.gov/NNDSS/beta/bcasedef.aspx?CondYrID=783&DatePub=1/1/2012

Immunization Division, Texas Department of Health
1100 West 49th St., Austin, TX 78756
(800) 252-9152 (512) 458-7544 fax

POSSIBLE SPREAD CONTACTS:

Name	Relation to Case	Age	Mumps Disease History			Mumps Vaccine History			
____________	______________	_____	☐ Yes-____________	☐ No	☐ Unknown	☐ 2 MMR	☐ 1 MMR	☐ None	☐ Unknown
____________	______________	_____	☐ Yes-____________	☐ No	☐ Unknown	☐ 2 MMR	☐1 MMR	☐ None	☐ Unknown
____________	______________	_____	☐ Yes-____________	☐ No	☐ Unknown	☐ 2 MMR	☐ 1 MMR	☐ None	☐ Unknown
____________	______________	_____	☐ Yes-____________	☐ No	☐ Unknown	☐ 2 MMR	☐ 1 MMR	☐ None	☐ Unknown
____________	______________	_____	☐ Yes-____________	☐ No	☐ Unknown	☐ 2 MMR	☐ 1 MMR	☐ None	☐ Unknown
____________	______________	_____	☐ Yes-____________	☐ No	☐ Unknown	☐ 2 MMR	☐ 1 MMR	☐ None	☐ Unknown

COMMENTS: