

# Mumps

Agency: \_\_\_\_\_

Investigator: \_\_\_\_\_

Phone number: \_\_\_\_\_

### FOR STATE USE ONLY

Status:  Confirmed  Probable  
 Suspect  Not a case

Reviewer initials: \_\_\_\_\_

Referred to another state: \_\_\_\_\_

## CASE

Last name: \_\_\_\_\_  
First and middle name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_

Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Gender:  Female  Male  Other \_\_\_\_\_

Address line: \_\_\_\_\_

Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Zip: \_\_\_\_\_ City: \_\_\_\_\_

Marital status:  Single  Married  Separated  
 Divorced  Parent with partner  Widowed

State: \_\_\_\_\_ County: \_\_\_\_\_

Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Long-term care resident:  Yes  No  Unknown

Parent/Guardian name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Parent/Guardian phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

## EVENT

Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown

Outbreak related:  Yes  No  Unknown

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Outbreak name: \_\_\_\_\_

Provider title:  ARNP  MD  DO  NP  PA

Exposure setting: \_\_\_\_\_

Facility name: \_\_\_\_\_

Epi-linked:  Yes  No  Unk To whom: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown

Address line 2: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_

Zip code: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Healthcare provider information

## LABORATORY FINDINGS

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: <b>Mumps virus</b>	Type (e.g. serotype): _____	

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: <b>Mumps virus</b>	Type (e.g. serotype): _____	

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: <b>Mumps virus</b>	Type (e.g. serotype): _____	

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

**CLINICAL INFO & DIAGNOSIS**

**Classic symptoms**

- Swelling OR pain of parotid gland:  Yes  No  Unk
- Swelling OR pain of sublingual or submandibular (submaxillary) glands:  Yes  No  Unk
- Did the glandular swelling or pain last at least 2 days:  Yes  No  Unk

**Other symptoms**

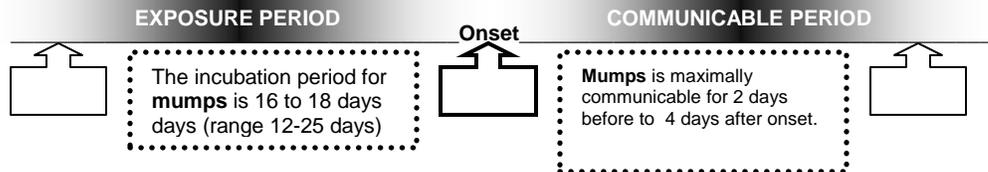
- Fever  Parotitis
- Orchitis  Swollen lymph nodes

**Complications**

- Aseptic meningitis
- Deafness

**INFECTION TIMELINE**

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



**RISK FACTORS/TRAVEL**

If pregnant during illness, how many weeks gestation was case at time of onset: \_\_\_\_\_

**Vaccinated for mumps:**  Yes  No  Unknown

Date vaccinated: _____ / _____ / _____	Date vaccinated: _____ / _____ / _____	Date vaccinated: _____ / _____ / _____
Lot #: _____	Lot #: _____	Lot #: _____
Vaccine type: _____	Vaccine type: _____	Vaccine type: _____
Manufacturer: _____	Manufacturer: _____	Manufacturer: _____

**Number of vaccinations:** \_\_\_\_\_

If not vaccinated, reason:  Lab evidence of previous disease  Religious exemption  Other  
 Medical contraindication  Under age 7 months  Unknown  
 Parental refusal

**Transmission setting:**  Day care  Hospital ward  Home  College  Church  
 School  Hospital ER  Work  Military  International travel  
 Doctor's office  Hospital outpatient clinic  Unknown  Correctional facility  Other

Disease traced within 2 generations of known international import?  Yes  No  Unk

**Risk Factors/Travel Information – In the 5 days prior to onset of symptoms had the case:**

Traveled within Iowa? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	City in Iowa: _____	Departure date: _____ / _____ / _____	Return date: _____ / _____ / _____
Traveled within U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	State: _____ City: _____	Departure date: _____ / _____ / _____	Return date: _____ / _____ / _____
Traveled outside U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Country: _____	Departure date: _____ / _____ / _____	Return date: _____ / _____ / _____

**CONTACTS**

**Number of people living in case's household:** \_\_\_\_\_

**Are there close contacts of the case with similar symptoms:**  Yes  No  Unknown

**Close contacts with similar symptoms**

Name	DOB	Gender	Address/Phone
_____	_____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - - -
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact <input type="checkbox"/> Child <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Sibling <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Roommate <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Unknown/Other	_____	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If this contact is a case create a new event and/or case for this contact.* ←

Name	DOB	Gender	Address/Phone
_____	_____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - - -
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact <input type="checkbox"/> Child <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Sibling <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Roommate <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Unknown/Other	_____	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If this contact is a case create a new event and/or case for this contact.* ←

NOTES:

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