



# Human Infection with 2019 Novel Coronavirus

Maven ID: \_\_\_\_\_  
 Interview Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Interviewed by Proxy\*:  Yes  No  
 Proxy Name: \_\_\_\_\_  
 Proxy Relationship: \_\_\_\_\_

*\*If patient has passed away, mark patient's death and end SF interview*

Did the patient die as a result of this illness?  Yes  No  Unknown If yes, date of death (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient First Name: _____	Patient Last Name: _____	Date of Birth (MM/DD/YYYY): ____/____/____
Address: _____		Phone: (____) _____ - _____ Email: _____
Resident Status: <input type="checkbox"/> Resident <input type="checkbox"/> Tourist* <input type="checkbox"/> Active Military <input type="checkbox"/> Military Dependent <i>*If tourist, collect both address within Hawaii and out of state address</i>		

## Case Demographics

Is a translator / interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  If yes, specify which language: _____  Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander. Specify: _____ <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian, specify: _____ <input type="checkbox"/> Black <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Other. Specify: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown  What is the patient's occupation/student status? <input type="checkbox"/> Accommodation / Food Services <input type="checkbox"/> Personal Care Services (Massage Therapists, Barber, Hairdresser, etc.) <input type="checkbox"/> Correctional Officer / Correctional Facility Worker <input type="checkbox"/> Other Occupation. Specify: _____ Workplace Name: _____ <input type="checkbox"/> Teacher / Educational Services Worker <input type="checkbox"/> Student / Day Care School / Day Care Name: _____ Grade / Class: _____ Last date at work/school prior to positive test? ____/____/____
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## Health Care Worker Information

Is the patient a health care worker in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, what type of health care work? <input type="checkbox"/> Direct Patient Care <input type="checkbox"/> Other Health Care Work If working directly with patients, respiratory therapist? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the patient's job setting? <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Adult Residential Care Home <input type="checkbox"/> Other <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Unknown

## Symptoms, Hospitalization, ICU, and Death

Symptoms present during course of illness: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Unknown <span style="float: right;">If case was symptomatic, onset date (MM/DD/YYYY): ____/____/____</span>	
If patient was symptomatic, symptoms: <input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Loss of Taste	
Was the patient hospitalized for COVID-19*? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, admission date (MM/DD/YYYY): ____/____/____
<i>*To be considered hospitalized, case must have spent at least one night within facility.</i>	If yes, discharge date (MM/DD/YYYY): ____/____/____

## Past Medical History

Did the patient have any underlying medical conditions and / or risk behaviors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chronic Lung Disease (Severe Asthma/Emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Chronic Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Immunosuppressive Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Current Smoker / Vape User	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Former Smoker / Vape User	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was the patient hospitalized for an illness other than COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Admission Date: ____/____/____ Discharge: ____/____/____	

## COVID-19 Testing

Why did the patient get tested? (referring to current positive test result) (check all that apply):	
<input type="checkbox"/> Notified of potential exposure <input type="checkbox"/> Close contact that tested positive <input type="checkbox"/> Hawaii DOH <input type="checkbox"/> AlohaSafe exposure notification app <input type="checkbox"/> Other exposure notification app. Specify: _____ <input type="checkbox"/> Educational facility / school / daycare <input type="checkbox"/> Other workplace <input type="checkbox"/> Other notification source. Specify: _____  <input type="checkbox"/> Developed symptoms consistent with COVID-19	<input type="checkbox"/> COVID-19 screening program (pre-travel, pre-procedure, etc.) <input type="checkbox"/> Pre-travel COVID-19 testing <input type="checkbox"/> Pre-procedure or prenatal (medical) COVID-19 screening <input type="checkbox"/> COVID-19 screening required by congregate residential setting (e.g., long-term care, care home, shelter) <input type="checkbox"/> COVID-19 screening offered by a workplace <input type="checkbox"/> COVID-19 screening offered for students at a school (e.g., preschool, K-12, or institute of higher education) <input type="checkbox"/> Other COVID-19 screening program. Specify: _____  <input type="checkbox"/> General concern. Specify: _____ <input type="checkbox"/> Other reason. Specify: _____
Was patient already in isolation / quarantine prior to receiving a positive COVID-19 result?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;">If yes, isolation start date: (MM/DD/YYYY): ____/____/____</span>	

## COVID-19 Vaccination Information

Has patient received the COVID-19 vaccine?  Yes  No

If yes, 1<sup>st</sup> Dose Information:

Vaccine Manufacturer:

- Pfizer  
 Moderna  
 AstraZeneca/Oxford  
 J&J (single dose)

Date Received First Dose (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If applicable, 2<sup>nd</sup> Dose Information:

Vaccine Manufacturer:

- Pfizer  
 Moderna  
 AstraZeneca/Oxford

Date Received second Dose (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Exposure Information

**In the 14 days prior to illness onset**, did the patient have any of the following exposures? (check all that apply):

Contact with a Known COVID-19 Case (Probable or Confirmed)

*If the patient had contact with a known COVID-19 case, what type of contact?*

- Household Contact  
 Community - Associated Contact  
 Healthcare - Associated Contact (Patient, Visitor, or Healthcare Worker)

Travel

- Interisland Travel. Specify Island(s): \_\_\_\_\_  
 Mainland U.S. Travel. Specify State(s): \_\_\_\_\_  
 International Travel. Specify Country(s): \_\_\_\_\_  
 Close Contact with any Visitor from Outside Hawaii  
 Cruise Ship or Vessel Travel (Passenger or Crew Member)

Congregate Settings

- Workplace  
 Adult Congregate Living Facility (Nursing, Assisted Living, Care Facility)  
 School / University / Childcare Center  
 Correctional Facility / Detention Center  
 Spas / Salons / Barbers  
 Gym / Weight Room / Yoga or Dance Studio  
 Community Event / Mass Gathering (Parties, Luau, Weddings, Funerals)

Other Exposures. Specify: \_\_\_\_\_

**Additionally, from the date 2 days prior to illness onset until now**, did the patient have any of the following exposures? (check all that apply):

Travel

- Interisland Travel. Specify Island(s): \_\_\_\_\_  
 Mainland U.S. Travel. Specify State(s): \_\_\_\_\_  
 International Travel. Specify Country(s): \_\_\_\_\_  
 Close Contact with any Visitor from Outside Hawaii  
 Cruise Ship or Vessel Travel (Passenger or Crew Member)

Congregate Settings

- Workplace  
 Adult Congregate Living Facility (Nursing, Assisted Living, Care Facility)  
 School / University / Childcare Center  
 Correctional Facility / Detention Center  
 Spas / Salons / Barbers  
 Gym / Weight Room / Yoga or Dance Studio  
 Community Event / Mass Gathering (Parties, Luau, Weddings, Funerals)

Last date at congregare setting prior to positive test? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Identified Risk Factor\*:  Travel International  Travel US  Contact with Travelers  Community

*\*As determined by answers to cases "Travel" questions and the "Identified Risk Factor Protocol" outlined within script*

Which best describes where the patient was staying at the time of illness onset?

Non-Congregate Housing

House / Single Family Home / Apartment / Condo / Mobile Home

If non-congregate housing, number of individuals living within same housing unit: \_\_\_\_\_

Healthcare/Assisted Living

Specify:

- Long-Term Care Facility / Nursing Home  
 Assisted Living Facility  
 Skilled Nursing Facility (SNF)  
 Acute Care Inpatient Facility  
 Rehabilitation Facility  
 Hospice

Unknown

Other. Specify: \_\_\_\_\_

Congregate housing

Specify:

- Dormitory  
 Homeless Shelter  
 Hotel/Motel  
 Correctional Facility  
 Group Home  
 Outside (Car / Other location not meant for habitation)

## Notes