2022 U.S. Monkeypox Outbreak
Short Case Report Form

Instructions for State, Local, and Territorial Health Jurisdictions: This form is an aid for public health officials when collecting essential data elements needed for investigating and reporting probable or confirmed monkeypox cases to CDC as part of the 2022 U.S. Monkeypox Outbreak response. Local public health officials may choose to use this fillable PDF for data collection within their jurisdiction, but data submission to CDC should be through established case surveillance systems and not through individually completed forms. Case information should always be captured electronically to minimize transcription errors; however, this form may be printed if needed.

Please visit the CDC Website for the latest public health information about monkeypox: www.cdc.gov/monkeypox

Note: This form is to be administered to the patient or their proxy–if the patient is deceased, administer with their proxy and/or healthcare provider.

Form Approved
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Short Case Report Form 2022 Monkeypox Outbreak

State-assigned case ID:

State/Territory of Residence:

County of Residence:

If you reside in a Tribal Area, please specify:

[FOR INTERVIEWER] Did the individual die from this illness?

◯ **Yes** ◯ **No** ◯ **Unknown**

If deceased, date of death:

Demographic Information

What is your age, in years?

What is your race? (check all that apply)

- ☐ **White**
- ☐ **African American or Black**
- ☐ **Asian**
- ☐ **Native Hawaiian/Pacific Islander**
- ☐ **American Indian/Alaska Native**
- ☐ **Multiple Races**
- ☐ **Unknown Race**
- ☐ **Other**
- ☐ **Declined to answer**

If the selected race is American Indian or Alaska Native, what is the tribal affiliation?

If you selected other for race, please specify:

What is your ethnicity? (check one):

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Declined to answer
- ☐ Unknown

Do you currently describe yourself as male, female, or transgender?

- ☐ Male
- ☐ Female
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Another gender identity
- ☐ Declined to answer

What sex were you assigned at birth, on your original birth certificate?

◯ Male ◯ Female ◯ Declined to answer ◯ Unknown

[FOR INTERVIEWER] Did the individual ever receive a vaccine against smallpox?

◯ Yes ◯ No ◯ Unknown

If yes, please give the reason, date, manufacturer, and dose number for each vaccine received:

	Reason	Vaccine Date	Vaccine Manufacturer	Dose Number
Vaccine 1	◯ Pre-exposure ◯ Post-exposure ◯ Routine pre-exposure ◯ Unknown		◯ MIP ◯ BN ◯ WAL	
Vaccine 2	◯ Pre-exposure ◯ Post-exposure ◯ Routine pre-exposure ◯ Unknown		◯ MIP ◯ BN ◯ WAL	
Vaccine 3	◯ Pre-exposure ◯ Post-exposure ◯ Routine pre-exposure ◯ Unknown		◯ MIP ◯ BN ◯ WAL	

***MIP = Emergent Biosolutions (ACAM2000); BN = Bavarian Nordic A/S (JYNNEOS); WAL = Wyeth (DryVax - prior to 2008)**

History of Possible Exposures

Did you engage in any sex (e.g., vaginal, oral or anal sex) and/or close intimate contact (e.g., cuddling, kissing, touching partner's genitals or anus, or sharing sex toys) in the three weeks before your first symptom appeared (also called symptom onset)?

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, indicate the number of partner(s) (including named and anonymous) below:

Male:

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, number of male partners or description if no number is provided:

[FOR INTERVIEWER]: If individual is unable to specify, provide a range of options for the number of male partners:

◯ **1** ◯ **2-4** ◯ **5-9** ◯ **10+** ◯ **Refused to answer**

Female:

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, number of female partners or description if no number is provided:

[FOR INTERVIEWER]: If individual is unable to specify, provide a range of options for the number of female partners:

◯ **1** ◯ **2-4** ◯ **5-9** ◯ **10+** ◯ **Refused to answer**

Transgender Female:

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, number of transgender female partners or description if no number is provided:

[FOR INTERVIEWER]: If individual is unable to specify, provide a range of options for the number of transgender female partners:

◯ **1** ◯ **2-4** ◯ **5-9** ◯ **10+** ◯ **Refused to answer**

Transgender Male:

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, number of transgender male partners or description if no number is provided:

[FOR INTERVIEWER]: If individual is unable to specify, provide a range of options for the number of transgender male partners:

◯ **1** ◯ **2-4** ◯ **5-9** ◯ **10+** ◯ **Refused to answer**

Other Gender Identity:

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, number of other gender identity partners or description if no number is provided:

[FOR INTERVIEWER]: If individual is unable to specify, provide a range of options for the number of other gender identity partners:

◯ **1** ◯ **2-4** ◯ **5-9** ◯ **10+** ◯ **Refused to answer**

[FOR INTERVIEWER] Specify if this case is epidemiologically linked to another confirmed or probable case:
If yes, please provide Case ID(s) (if known) and contact type:

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, please provide CDC assigned Case ID. Enter International if not a U.S. Case, or enter "unknown" if unknown

If yes, please provide State assigned Case ID.

Contact type:

- ☐ **Providing care to case – home setting**
- ☐ **Indirect contact (e.g., shared sexual partners)**
- ☐ **Sexual (e.g., vaginal, oral, or anal sex) or intimate contact (e.g., cuddling, kissing, touching partner's genitals or anus, or sharing sex toys)**
- ☐ **Shared food, utensils, or dishes**
- ☐ **Shared towels, bedding, or clothing**
- ☐ **Shared transportation (e.g., carpooling, riding a bus, rising a motorcycle, using a taxi, using Uber) (specify mode of transportation)**

☐ **Shared bathrooms (toilets, sinks, showers)**

☐ **Face-to-face contact, not including intimate contact (being within six feet for more than three hours of an unmasked case-patient without wearing, at a minimum, a surgical mask)**

☐ **Health care worker**

☐ **Identified air contact**

☐ **Other**

If other, please specify:

Travel

If you spent time

- **in a country outside the U.S., or**
- **in a state/territory outside your home state/territory**

during the 3 weeks before your first symptom appeared (also called symptom onset), please report all travel events below:

Was the travel event domestic or international?

◯ **Domestic** ◯ **International**

Domestic Travel:

States traveled to:

Date of departure (MM/DD/YYYY):

Date of return (MM/DD/YYYY):

Did you have intimate or sexual contact with new partners on trip?

◯ **Yes** ◯ **No** ◯ **Unknown**

[FOR INTERVIEWER] Any additional comments on travel within the US that may be important:

International Travel:

Country traveled to:

Date of departure (MM/DD/YYYY):

Date of return to US (MM/DD/YYYY):

Did you have any intimate or sexual contact with new partners on trip?

◯ **Yes** ◯ **No** ◯ **Unknown**

[FOR INTERVIEWER] Any additional comments on travel outside the US that may be important?

[FOR INTERVIEWER] Is this individual a health care worker who was exposed at work?

◯ **Yes** ◯ **No** ◯ **Unknown**

[FOR INTERVIEWER] Please provide the suspect location of exposure

◯ **International** ◯ **Domestic** ◯ **Air Travel Contact** ◯ **Other** ◯ **Unknown**

[FOR INTERVIEWER] If other, please specify the suspect location of exposure.

[FOR INTERVIEWER] Please provide any additional details on the location of exposure (e.g., health care setting, large gathering, private party)

[FOR INTERVIEWER] Please provide the number of identified contacts this case may have exposed (either named or anonymous)

Diagnostic Testing Information

What laboratory performed the testing?

◯ **LRN Member Lab**

◯ **Commercial Lab**

◯ **Academic/Hospital Lab**

◯ **Unknown**

Performing lab specimen IDs (i.e. a laboratory generated number that identifies the specimen related to this test)

What was the orthopox virus test result?

◯ **OPX+** ◯ **OPX-** ◯ **Inconclusive** ◯ **Unknown**

What was the test result date?

Clinical Information

What signs or symptoms did you experience during the course of your illness?:

Fever:
◯ **Yes** ◯ **No** ◯ **Unknown**

Rash:
◯ **Yes** ◯ **No** ◯ **Unknown**

Enlarged Lymph Nodes:
◯ **Yes** ◯ **No** ◯ **Unknown**

Pruritis (itching):
◯ **Yes** ◯ **No** ◯ **Unknown**

Rectal Pain:
◯ **Yes** ◯ **No** ◯ **Unknown**

Rectal Bleeding:
◯ **Yes** ◯ **No** ◯ **Unknown**

Pus or blood on stools:
◯ **Yes** ◯ **No** ◯ **Unknown**

Proctitis:
◯ **Yes** ◯ **No** ◯ **Unknown**

Tenesmus/urgency to defecate:
◯ **Yes** ◯ **No** ◯ **Unknown**

Headache:
◯ **Yes** ◯ **No** ◯ **Unknown**

Malaise (general feeling of illness or weakness):
◯ **Yes** ◯ **No** ◯ **Unknown**

Conjunctivitis:
◯ **Yes** ◯ **No** ◯ **Unknown**

Abdominal Pain:
◯ **Yes** ◯ **No** ◯ **Unknown**

Vomiting or Nausea:
◯ **Yes** ◯ **No** ◯ **Unknown**

Myalgia (muscle aches):

◯ Yes ◯ No ◯ Unknown

Chills:

◯ Yes ◯ No ◯ Unknown

What day was the date of your illness onset (the date any symptoms mentioned above first started)?

Did you have a rash during the course of your illness?

◯ Yes ◯ No ◯ Unknown

If yes, what was the date of rash onset (in other words, the date the rash first appeared)?

☐ Unknown

If yes, where on your body is the rash? (choose all that apply)

- ☐ Face
- ☐ Head
- ☐ Neck
- ☐ Mouth
- ☐ Lips or oral mucosa
- ☐ Trunk
- ☐ Arms
- ☐ Legs
- ☐ Palms of hands
- ☐ Soles of feet
- ☐ Genitals
- ☐ Perianal
- ☐ Other locations

If other, please specify

[FOR INTERVIEWER] Any evidence of ocular involvement (ocular lesions, keratitis, conjunctivitis, eyelid lesions)?

◯ Yes ◯ No ◯ Unknown

[FOR INTERVIEWER] Has this individual been diagnosed with any acute infections other than monkeypox during this current illness/or within the last three weeks? (e.g., gonorrhea, chlamydia, syphilis, HSV, other STI, varicella)

◯ Yes ◯ No ◯ Unknown

If yes, please specify infections

[FOR INTERVIEWER] What is the individual's HIV status?

◯ **HIV Positive** ◯ **HIV Negative** ◯ **Unknown**

If HIV positive, was the individual's viral load undetectable when it was last checked?

◯ **Yes** ◯ **No** ◯ **Unknown**

Does the individual have any known immunocompromising conditions (excluding HIV) or take immunosuppressive medications? Immunocompromising conditions can include organ transplants, stem cell transplants, and active cancer. Certain medicines like chemotherapy, biologic therapies, and steroids can also weaken the immune system.

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, describe the associated condition or treatment

Has the individual been hospitalized for monkeypox?

◯ **Yes** ◯ **No** ◯ **Unknown**

If yes, what was the reason for the hospitalization? (choose all that apply)

- ☐ **Breathing problems requiring mechanical ventilation**
- ☐ **Breathing problems not requiring mechanical ventilation**
- ☐ **Treatment for secondary infection**
- ☐ **Pain control**
- ☐ **Disseminated disease**
- ☐ **Exacerbation of underlying condition (e.g. autoimmune or skin condition)**
- ☐ **Other**

If other, specify:

Individual's most recent admission date to the hospital for the condition covered by the investigation:

Individual's most recent discharge date from the hospital for the condition covered by the investigation:

[FOR INTERVIEWER] Is the individual currently receiving HIV pre-exposure prophylaxis?

◯ **Yes** ◯ **No** ◯ **Unknown**

Are you currently pregnant?

◯ **Yes** ◯ **No** ◯ **Unknown**

Are you currently breastfeeding?

◯ **Yes** ◯ **No** ◯ **Unknown**

[FOR INTERVIEWER] Please use this space to include any additional notes or comments.