Form 1: Smallpox Post-Event Surveillance Form

Please print

OMB No. 0920-0008  Exp. Date: 06/2003

Circled numbers indicate the minimum required fields. Every attempt should be made to at least complete the circled items.

1. CASE NAME:
   - Last
   - First
   - Middle
   - Suffix
   - Nickname/ Alias

2. ADDRESS:
   - Street Address, Apt #
   - City
   - State
   - Zip Code

3. TELEPHONE:
   - Home: Area Code Number Work: Area Code Number

4. DATE OF BIRTH:
   - Month
   - Day
   - Year

5. AGE:
   - Years
   - Months
   - Day

6. RACE (Check all that apply):
   - Am. Indian/Alaska Native
   - Asian
   - Black/African Am.
   - Native Hawaiian/Pacific Islander
   - Unknown

7. GENDER:
   - Male
   - Female

8. ETHNICITY:
   - Hispanic
   - Non-Hispanic

<table>
<thead>
<tr>
<th>DATE First REPORTED TO PUBLIC HEALTH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

10. REPORTED BY:
   - Name/Institution
   - Area Code Number

11. REPORTED BY PHONE NUMBER:
   - Area Code Number

12. FORM INITIATED BY:
    - INTERVIEWER NAME
    - Last
    - First
    - Middle

13. INTERVIEW DATE:
    - Month
    - Day
    - Year

14. INFORMATION PROVIDED BY:
    - Informant: Last
    - First
    - Middle

15. TELEPHONE NUMBER OF INFORMANT:
    - Area Code Number

16. PRIMARY INTERVIEW LANGUAGE SPOKEN:

<table>
<thead>
<tr>
<th>VACCINATION AND MEDICAL HISTORY</th>
</tr>
</thead>
</table>

27. SMALLPOX VACCINATION:
   - PRIOR TO THIS OUTBREAK:
     - Yes
     - No
     - Unknown
   - IF YES, NUMBER OF DOSES:
     - One
     - More than one
   - IF KNOWN: AGE (YEARS) OR YEAR OF LAST DOSE

28. SMALLPOX VACCINATION SCAR PRESENT:
   - Yes
   - No
   - Unknown

29. SMALLPOX VACCINATION:
   - DURING THIS OUTBREAK:
     - Yes
     - No
     - Unknown
   - IF YES, DATE OF VACCINATION:
     - Month
     - Day
     - Year

30. VACCINE "TAKE" RECORDED:
   - Yes
   - No
   - Unknown
   - Major
   - Minor
   - Unrecorded

31. IF NOT VACCINATED DURING THIS OUTBREAK, GIVE REASON:
   - Patient refusal
   - Medical contraindication
   - Unavailable of need to be vaccinate
   - Other, specify:

32. IF FEMALE, PREGNANT:
   - Yes
   - No
   - Unknown

33. PRE-EXISTING IMMUNOCOMPROMISING MEDICAL CONDITIONS (I.e., leukemia, other cancers, hiv/AIDS):
   - Yes
   - No
   - Unknown

34. DURING THE PAST MONTH, ANY PRESCRIBED IMMUNOCOMPROMISING OR IMMUNOMODULATING MEDICATIONS INCLUDING STEROIDS:
   - Yes
   - No
   - Unknown
   - IF YES, PLEASE SPECIFY:

35. FOR WHAT MEDICAL CONDITION:

<table>
<thead>
<tr>
<th>CURRENT ILLNESS</th>
</tr>
</thead>
</table>

36. HAS THE PATIENT HAD A FEVER AS PART OF THIS ILLNESS:
   - IN THE 4 DAYS PRIOR TO RASH ONSET:
     - Yes
     - No
     - Unknown
   - IF YES, ESTIMATED DATE OF FEVER ONSET:
     - Month
     - Day
     - Year

37. WAS TEMPERATURE MEASURED WITH A THERMOMETER:
   - Yes
   - No
   - Unknown

38. MAXIMUM TEMPERATURE:
   - °F
   - °C
   - (Circle)

39. DATE OF MAXIMUM FEVER:
   - Month
   - Day
   - Year

40. DATE OF RASH ONSET:
   - Month
   - Day
   - Year

41. COUGH WITH RASH/ILLNESS:
   - Yes
   - No
   - Unknown

42. DATE OF COUGH ONSET:
   - Month
   - Day
   - Year

43. SYMPTOMS DURING THE 4 DAYS PRECEDING RASH ONSET:
   - Headache:
     - Yes
     - No
     - Unknown
   - Backache:
     - Yes
     - No
     - Unknown
   - Chill:
     - Yes
     - No
     - Unknown
   - Vomiting:
     - Yes
     - No
     - Unknown
   - Other (e.g., abdominal pain, delirium):
     - Yes
     - No
     - Unknown

44. DISTRIBUTION OF LESIONS:
   - generalized, predominantly face and distal extremities (centrifugal)
   - generalized, predominantly trunk (centripetal)
   - Localized, not generalized
   - Other, specify:

45. CLINICAL TYPE OF SMALLPOX:
   - Ordinary/Classic type:
     - Yes
     - No
     - Unknown
   - Discrete lesions
   - Semi-confluent – Face only
   - Confluent – Face and other site
   - Varicella sine eruptions
   - Modified type
   - Flat type
   - Hemorrhagic type:
     - Early
     - Late

Public reportable burden of this collection of information is estimated to average _ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATS/ Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).
**CLINICAL COURSE**

41. DATE LAST SCAB FELL OFF:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

OR CHECK IF UNKNOWN

42. DID THE PATIENT DEVELOP:

<table>
<thead>
<tr>
<th>ANY COMPLICATIONS:</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin, infected lesions, abscesses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corneal ulcer or keratitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

43. ANTIVIRAL MEDICATION (CIDOFIVIR):

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>
| Date Started:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

DURATION: ___________ DAYS

44. OTHER ANTIVIRAL MEDICATIONS GIVEN:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IF YES, SPECIFY:

**LABORATORY, CONT.**

**VARIELA SPECIFIC TESTS**

52. VARIOLA

<table>
<thead>
<tr>
<th>SPECIMEN TYPE:</th>
<th>MM</th>
<th>DD</th>
<th>YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crust</td>
<td>CSF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53. VARIOLA CULTURE WITH VARIOLA PCR CONFIRMATION

<table>
<thead>
<tr>
<th>SPECIMEN TYPE:</th>
<th>MM</th>
<th>DD</th>
<th>YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crust</td>
<td>CSF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VACCINIA SPECIFIC TEST**

54. VACCINIA

<table>
<thead>
<tr>
<th>SPECIMEN TYPE:</th>
<th>MM</th>
<th>DD</th>
<th>YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crust</td>
<td>CSF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

55. OTHER TESTING PERFORMED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IF YES, SPECIFY:

**CLINICAL OUTCOME**

45. WAS CASE ADMITTED TO HOSPITAL?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

HOSPITAL LOCATION:

<table>
<thead>
<tr>
<th>DATE ADMITTED:</th>
<th>DATE DISCHARGED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

46. WAS CASE ADMITTED/TRANSFERRED TO 2ND HOSPITAL?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

HOSPITAL LOCATION:

<table>
<thead>
<tr>
<th>DATE ADMITTED:</th>
<th>DATE DISCHARGED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

47. DID THE PATIENT DIE FROM SMALLPOX ILLNESS OR ANY SMALLPOX COMPLICATIONS?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IF YES, DATE OF DEATH:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**VACCINIA SPECIFIC TEST**

54. VACCINIA

<table>
<thead>
<tr>
<th>SPECIMEN TYPE:</th>
<th>MM</th>
<th>DD</th>
<th>YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crust</td>
<td>CSF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

55. OTHER TESTING PERFORMED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IF YES, SPECIFY:

**EPIDEMIOLOGIC**

56. TRANSMISSION SETTING:

<table>
<thead>
<tr>
<th>Athletics</th>
<th>College</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daycare</td>
<td>Dr. Office</td>
<td>Correctional facility</td>
</tr>
<tr>
<td>Home</td>
<td>Hospital</td>
<td>Int'l travel</td>
</tr>
<tr>
<td>Military</td>
<td>School</td>
<td>Place of worship</td>
</tr>
<tr>
<td>Work</td>
<td>Other</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**CASE CLASSIFICATION**

57. DOES THIS CASE MEET THE CLINICAL CASE DEFINITION?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IS THIS CASE EPIDEMIOLOGICALLY LINKED TO A CONFIRMED CASE?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IS THIS CASE LABORATORY-CONFIRMED?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Unknown</th>
</tr>
</thead>
</table>

IS WHAT THE CASE CLASSIFICATION?

<table>
<thead>
<tr>
<th>Confirmed</th>
<th>Probable</th>
<th>Suspect</th>
</tr>
</thead>
</table>

61. IF NOT SMALLPOX, SPECIFY FINAL DIAGNOSIS:

**ORTHOPHOX GENERIC TESTS**

50. ORTHOPHOX PCR

<table>
<thead>
<tr>
<th>SPECIMEN TYPE:</th>
<th>MM</th>
<th>DD</th>
<th>YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crust</td>
<td>CSF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

51. ELECTRON MICROSCOPY (EM)

<table>
<thead>
<tr>
<th>SPECIMEN TYPE:</th>
<th>MM</th>
<th>DD</th>
<th>YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Smallpox Clinical Case Definition:** An illness with acute onset of fever ≥ 101°F followed by a rash characterized by firm, deep seated vesicles or pustules in the same stage of development without other apparent cause.

**Laboratory Criteria for Confirmation:** Polymerase chain reaction (PCR) identification of variola DNA in a clinical specimen; OR isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only).

Note: Orthopox PCR and negative stain electron microscopy (EM) identification of a pox virus in a clinical specimen suggest orthopox virus infection but are not diagnostic of variola and/or reovirus. (Level D laboratory or approved Level C laboratory) Level D laboratories include the CDC and USAMMRD. Initial confirmation of a smallpox outbreak requires testing in a Level D laboratory. Level C laboratories will assist with testing of clinical specimens following initial confirmation of an outbreak by CDC.

**Smallpox Case Classification:** Confirmed case = A case of smallpox that is laboratory confirmed, OR a case that meets the clinical case definition that is epidemiologically linked to a laboratory confirmed case. Probable case = A case that meets the clinical case definition, OR a case that has an atypical presentation that has an epidemiological link to a confirmed case of smallpox. Apparent presentations of smallpox are: a) Hemorrhagic type, b) Fat type, not appearing as typical vesicles progressing to pustules and variola sine eruptions. Suspect case = Case with a febrile rash illness with fever preceding development of rash by 1-4 days.
Form 2A: Smallpox Case Travel/Activity Worksheet - Infectious Period

Please print

1. State

2. Case #

OMB NO. 0920-0008
Exp. Date: 06/2003

3. CASE NAME: ________________________________
   Last ___________ First ___________ Middle ___________ Suffix ___________ Nickname/Alias ___________

4. Interviewer Name: ________________________________
   Last ___________ First ___________ Middle ___________

5. Interview Date: _______ _______ _______ / / YYYY

6. Date of fever onset: _______ _______ / / YYYY

F=Fever, R=Rash, C=Cough

RECORD ANY ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
</tr>
<tr>
<td>□ F</td>
<td>□ F</td>
<td>□ F</td>
<td>□ F</td>
<td>□ F</td>
<td>□ F</td>
<td>□ F</td>
</tr>
<tr>
<td>□ R</td>
<td>□ R</td>
<td>□ R</td>
<td>□ R</td>
<td>□ R</td>
<td>□ R</td>
<td>□ R</td>
</tr>
<tr>
<td>□ C</td>
<td>□ C</td>
<td>□ C</td>
<td>□ C</td>
<td>□ C</td>
<td>□ C</td>
<td>□ C</td>
</tr>
</tbody>
</table>

START HERE

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Page 1 of 1
Form 2A (Draft 11/26/2002) Version 3.0
Form 2B: Smallpox Primary Contact/Site Worksheet

Please print

1. State [ ] 2. Case # [ ]

OMB NO. 0920-0008
Exp. Date: 06/2003

3. CASE NAME: ________________________________
   Last     First     Middle     Suffix     Nickname/Alias

4. Interviewer Name: ________________________________
   Last     First     Middle

5. Interview Date: MM/DD/YYYY

6. Date of fever onset: MM/DD/YYYY

*Contact Priority Category Codes:
1 = (Highest priority) Case household contacts: all immediate family members; others spending ≥ 3 hours in the household since case's onset of rash
2 = Non-household contacts with contact < 6 feet with case with rash for ≥ 3 hours
3 = Non-household contacts with contact < 6 feet with case with rash for < 3 hours
4 = Non-household contacts with contact ≥ 6 feet with case with rash for ≥ 3 hours
5 = Non-household contacts with contact ≥ 6 feet with case with rash for < 3 hours

<table>
<thead>
<tr>
<th>Name of Person (Last, First) and/or Name of Site</th>
<th>Date of First Exposure</th>
<th>Date of Last Exposure</th>
<th>Distance in Feet</th>
<th>Duration in Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>&lt;6ft</td>
<td>&lt;3</td>
<td>≥ 3</td>
</tr>
</tbody>
</table>

Public reporting burden of this collection of information is estimated to average ______ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Page ____ of ____
Form 2B (Draft 11/26/2002) Version 3.0
Form 2C: Smallpox Case Transportation Worksheet – Infectious Period

Please print

1. State [ ]
2. Case # [ ]

3. CASE NAME:
   Last / First / Middle / Suffix / Nickname/Alias

4. Interviewer Name:
   Last / First / Middle

5. Interview Date: [ ]

6. Date of fever onset: [ ]

COMPLETE AS MUCH INFORMATION AS POSSIBLE FOR EACH TYPE OF TRANSPORTATION USED BY CASE SINCE FEVER ONSET.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Public reporting burden of this collection of information is estimated to average ___ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Page ___ of ___

Form 2C (Draft 11/26/2002) Version 3.0
**Form 2D: Smallpox Contact Tracing Form**

1. Last Name: [ ]
   First Name: [ ]
   MI: [ ]
   Suffix: [ ]
   Alias: [ ]

2. Street Address: [ ]
   Apt #: [ ]

3. City: [ ]
   State: [ ]
   Zip: [ ]

4. DOB: [ ]
   M: [ ]
   D: [ ]
   Y: [ ]
   Y: [ ]

5. Age (Yrs): [ ]
   H: [ ]
   N: [ ]
   V: [ ]

6. Ethnicity: [ ]
   A/LAN: [ ]
   Asian: [ ]
   B/AI: [ ]
   H/II: [ ]
   O/U: [ ]
   White: [ ]

7. Race: [ ]
   M: [ ]
   F: [ ]

8. Sex: [ ]

9. Phone Number - Home: [ ]

10. Phone Number - Cell: [ ]

11. Phone Number - Work: [ ]

12. Phone Number - Other: [ ]

13. Height: [ ]
   Size/Build: [ ]
   Hair: [ ]

14. Complexion: [ ]
   Pregnancy?: [ ]

15. Primary Language Spoken: [ ]
   English Spoken: [ ]

16. Name of Employer/School: [ ]

17. Work Hours: [ ]

24. Exposure Dates:
   Date of First Exposure: [ ]
   Date of Last Exposure: [ ]

25. Reported Case Number: [ ]

26. Date Interview of Reported Case: [ ]

27. Contact Type (Mark One)
   Primary Contact: [ ]
   Secondary Contact: [ ]

28. Priority Code: [ ]

29. Primary Contact Form 2D Number:
   (Complete only for Secondary Contacts) [ ]

30. Location, Epi Notes, and Other Relevant Information:

31. Disposition (Select One)
   Located:
   1A Referred for Vaccination, Fever or Rash or Cough Not Present
   1B Referred for Clinical Assessment, Fever or Rash or Cough Present
   1C Already Hospitalized as Suspected Case, Fever or Rash or Cough Present
   1D Isolated, Not Vaccinated (within last 6 months), Fever or Rash or Cough Not Present
   1E Previously Vaccinated (within last 6 months), Fever or Rash or Cough Not Present

   Not Located:
   2A Unable to Locate
   2B Moved From Jurisdiction, To [ ]

   Deceased:
   3A Smallpox Suspected
   3B Unrelated to Smallpox

   Other:
   4 [ ]

40. Smallpox Case ID:

41. Reviewed By: [ ]

Form 2D (Draft 11/26/2002) Version 3

---

Public reporting burden of this collection of information is estimated to average... minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer: 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).
Form 2E: Smallpox Case Household and Primary Contact Surveillance Form

I. CASE INFORMATION (Filled out by interviewer)

1. CASE ID:

II. HOUSEHOLD OR PRIMARY CONTACT INFORMATION (Questions marked with (*) to be filled out by interviewer)

2. DATE OF HOUSEHOLD VISIT: MM DD YYYY

3. NAME OF CASE HOUSEHOLD OR PRIMARY CONTACT:
   Last
   First
   Middle
   Suffix
   Nickname/Alias

4. SEX (Circle): Male Female

5. AGE: 

6. HOUSEHOLD CONTACT/PRIMARY CONTACT FORM 2D#

7. DATE OF LAST EXPOSURE TO CASE: MM DD YYYY

8. DATE VACCINATED: MM DD YYYY

9. CALL BACK DATE (7 days after vaccination): MM DD YYYY

III. HOUSEHOLD OR PRIMARY CONTACT CLINICAL SIGNS TRACKING
(Filled out by Household or Primary Contact)

10. Record your temperature each day in the boxes below. If fever is 101°F or greater for two consecutive days, call the number provided immediately:

|--------------------------|------|------|------|------|------|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

11. *[Insert telephone number or sticker here]

12. If rash develops, mark the day the rash started below, and call the number provided:

|------|------|------|------|------|------|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

13. If you develop any of the severe vaccine adverse reactions shown on the Vaccination Information Statement, call:

14. *[Insert telephone number or sticker here]

15. For non-emergencies or if you have questions, call:

16. *[Insert telephone number or sticker here]
Form 2F: Smallpox Case Primary Contact's Household Members Surveillance Form

I. CASE INFORMATION (Filled out by interviewer)

1. CASE ID: ____________________________________________________________

II. PRIMARY CONTACT INFORMATION (Questions marked with (*) to be filled out by interviewer)

*2. DATE OF HOUSEHOLD VISIT: ______/____/____
   MM   DD   YYYY

*3. NAME OF PRIMARY CONTACT: __________________________________________
   Last Name               First Name          Middle Name       Suffix

*4. PRIMARY CONTACT FORM 2D# ______________________________________________

III. INFORMATION ABOUT PRIMARY CONTACT'S HOUSEHOLD MEMBERS (Filled out by primary contact or household member)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MM/ DD/ YYYY</td>
<td>MM/ DD/ YYYY</td>
</tr>
</tbody>
</table>

12. If anyone develops any of the severe vaccine adverse reactions shown on the Vaccination Information Statement, call: 

13. *[Insert telephone number or sticker here]

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Page ___ of ___

Form 2F (Draft 11/26/2002) Version 3.0
Form 3A: Smallpox Case Exposure Investigation Form

Case Exposure/Source Information

4. CASE NAME: ____________________________ (Last) ____________________________ (First) ____________________________ (Middle) ____________________________ (Suffix) ____________________________ (Nickname)

5. ADDRESS: ____________________________ Street Address, Apt # _______ City _______ State _______ Zip Code _______

6. Case Classification: □ Confirmed □ Probable □ Suspect □ Unknown

Information on possible source of infection - INDIVIDUALS

7. DO YOU KNOW FROM WHOM YOU CAUGHT THIS ILLNESS? □ Yes □ No □ Unknown

IF NO OR UNKNOWN, GO TO QUESTION 10.

IF YES, GIVE NAME, ADDRESS, AND TELEPHONE NUMBER

Name (LAST, FIRST) ____________________________ Street Address, Apt # _______ City _______ State _______ Zip Code _______ Area Code _______ Number _______

8. DATE OF LAST EXPOSURE: _______ _______ _______

Month Day Year

9. DID THE PERSON HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS (MARK ALL THAT APPLY):

☐ RASH: PAPULES/BUMPS ☐ FEVER ☐ SEVERELY ILL ☐ OTHER, DESCRIBE: ____________________________

☐ RASH: VESICLES ☐ COUGH ☐ IMMOBILE

☐ RASH: PUSTULES (FLUID FILLED) ☐ RASH: CRUSTS/GSABS

10. DO YOU KNOW OF ANY OTHER PERSON WITH AN ILLNESS LIKE YOURS? □ Yes □ No □ Unknown

IF YES, GIVE NAME, ADDRESS, AND TELEPHONE NUMBER

Name (LAST, FIRST) ____________________________ Street Address, Apt # _______ City _______ State _______ Zip Code _______ Area Code _______ Number _______

11. DURING THE DATES FROM _______ _______ _______ TO _______ _______ _______ BEFORE YOUR RASH ONSET, WERE YOU IN CONTACT WITH:

DO YOU KNOW OF ANYONE WHO APPEARED TO HAVE:

11a. CHICKENPOX: □ Yes □ No □ Unknown

11b. A SEVERE RASH ON THE FACE AND/OR ARMS: □ Yes □ No □ Unknown

IF YES TO 11a OR 11b, GIVE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE INDIVIDUALS:

Name (LAST, FIRST) ____________________________ Street Address, Apt # _______ City _______ State _______ Zip Code _______ Area Code _______ Number _______

DATE OF LAST EXPOSURE: _______ _______ _______

Month Day Year

Name (LAST, FIRST) ____________________________ Street Address, Apt # _______ City _______ State _______ Zip Code _______ Area Code _______ Number _______

DATE OF LAST EXPOSURE: _______ _______ _______

Month Day Year

Information on possible source of infection - PLACE

12. DO YOU KNOW WHERE YOU CAUGHT THIS ILLNESS? □ Yes □ No □ Unknown

IF YES, NAME OF PLACE/EVENT: ____________________________ TYPE OF PLACE/EVENT: ____________________________ (i.e., restaurant, store, theater, sports event, office, etc)

ADDRESS / LOCATION ____________________________ Street Address, Apt # _______ City _______ State _______ Zip Code _______

DESCRIBE LOCATION ____________________________ TELEPHONE: _______ _______ _______

Area Code _______ Number _______

13. POSSIBLE DATE OF EXPOSURE: _______ _______ _______

Month Day Year

14. TIME: ______________________ AM / PM

15. ESTIMATED NUMBER OF PERSONS POTENTIALLY EXPOSED AT THE SAME PLACE AND TIME AS CASE: ____________________________

LIST OTHERS POTENTIALLY EXPOSED (NAME, ADDRESS, TELEPHONE) ON REVERSE SIDE OF THIS FORM OR ON AN ADDITIONAL PIECE OF PAPER.

Public reporting burden of this collection of information is estimated to average ____ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Page 1 of 2
Form 3A (Draft 11/26/2002) Version 3.0
### LIST OF NAMES AND ADDRESSES/TELEPHONE NUMBERS:

<table>
<thead>
<tr>
<th>Name/Location</th>
<th>Street Address, Apt #</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Area Code</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SAMPLE QUESTIONS FOR FORM 3B: SMALLPOX CASE TRAVEL/ACTIVITY WORKSHEET – EXPOSURE PERIOD:

For the next few questions, I'd like you to think back to the 14-day period between 1 and 3 weeks before you developed a rash that we have marked on the calendar. Let's start with weekdays. (Offer dates, holidays, etc., as available to anchor the case's recall to this time period. Consider routine weekday activities in a systematic way going either back from day 7 or forward from day 21 from fever onset depending on what seems easier to do.)

For weekends, ask about usual routines and then occasional activities. Prompt especially for attendance at public events. A question to capture this type of attendance follows after questions regarding usual activities.

**WHAT IS YOUR USUAL ROUTINE:**

- **DO YOU WORK?**
  - [ ] Yes
  - [ ] No
  - [ ] Yes, on a regular basis
  - [ ] No

- **DO YOU GO TO SCHOOL?**
  - [ ] Yes
  - [ ] No
  - [ ] Yes, another day activity
  - [ ] No

**DURING THIS 14-DAY PERIOD AS SHOWN ON THIS CALENDAR, DID YOU SPEND ANY TIME REGULARLY (3 OR MORE TIMES A WEEK) IN THE FOLLOWING PLACES?**

- **WORK:**
  - [ ] Yes
  - [ ] No
- **SCHOOL:**
  - [ ] Yes
  - [ ] No
- **RESTAURANT:**
  - [ ] Yes
  - [ ] No
- **GROCERY STORE:**
  - [ ] Yes
  - [ ] No
- **YOUR CHILD’S SCHOOL OR DAY CARE CENTER:**
  - [ ] Yes
  - [ ] No
- **OTHER, SUCH AS PLACE OF WORSHIP, GYM, ETC.:**
  - [ ] Yes
  - [ ] No

If YES, specify:

**Please complete FORM 3C – CASE EXPOSURE TRANSPORTATION WORKSHEET for all transportation questions.**

**IF YOU WORK, GO TO SCHOOL, OR TRANSPORT YOUR CHILDREN OR OTHER FAMILY MEMBERS, HOW DO YOU TRAVEL TO AND FROM THESE PLACES?**

- **CAR ALONE, BICYCLE, WALK:**
  - [ ] Yes
  - [ ] No
  - [ ] Car with other people in the vehicle at least sometimes:
    - [ ] Yes
    - [ ] No
- **BUS, TRAIN OR SUBWAY:**
  - [ ] Yes
  - [ ] No
  - [ ] Taxi:
    - [ ] Yes
    - [ ] No
- **OTHER, SPECIFY (E.G., PLANE):**
  - [ ] Yes
  - [ ] No

If YES, specify:

**NOTE:** For regular travel schedule such as to and from work, indicate range of days and times if this is the same each day.

**DURING THE 14-DAY TIME PERIOD DESIGNATED ABOVE, DID YOU TRAVEL OUT OF TOWN (IF CITY, OUT OF URBAN AREA, IF RURAL, OUT OF COUNTY)?**

- [ ] Yes
- [ ] No

**DURING THE 14-DAY TIME PERIOD DESIGNATED ABOVE, DID YOU VISIT ANY OF THE FOLLOWING ACTIVITIES AT LEAST ONCE?**

- **HOTEL/CONVENTION CENTER:**
  - [ ] Yes
  - [ ] No
  - [ ] Church, temple, mosque, or other place of worship:
    - [ ] Yes
    - [ ] No
- **SHOPPING MALL OR LARGE STORE:**
  - [ ] Yes
  - [ ] No
  - [ ] Doctor’s office, emergency room, clinic or hospital:
    - [ ] Yes
    - [ ] No
- **AIRPORT:**
  - [ ] Yes
  - [ ] No
  - [ ] Theater (movies/play):
    - [ ] Yes
    - [ ] No
- **CONCERT:**
  - [ ] Yes
  - [ ] No
  - [ ] Public sporting event:
    - [ ] Yes
    - [ ] No
- **BUS, TRAIN OR SUBWAY:**
  - [ ] Yes
  - [ ] No
  - [ ] Fair, festival, or carnival:
    - [ ] Yes
    - [ ] No
- **ANY OTHER GATHERING WITH MORE THAN 100 OTHER PEOPLE:**
  - [ ] Yes
  - [ ] No

If YES, specify:

---

Page 2 of 2

Form 3A (Draft 11/26/2002) Version 3.0
Form 3B: Smallpox Case Travel/Activity Worksheet – Exposure Period

Please print

1. State

2. Case #

OMB NO. 0920-0008

Exp. Date: 06/2003

3. CASE NAME:

   Last
   First
   Middle
   Suffix
   Nickname/Alias

4. Interviewer Name:

   Last
   First
   Middle

5. Interview Date: MM DD YYYY

6. Date of case fever onset: MM DD YYYY

   RECORD ANY ADDITIONAL INFORMATION ON THE REVERSE SIDE OF THIS FORM

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
</tr>
<tr>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
</tr>
<tr>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
</tr>
<tr>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
<td>DATE:</td>
</tr>
</tbody>
</table>

START HERE

Public reporting burden of this collection of information is estimated to average ___ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Page 1 of 1
Form 3B (Draft 11/26/2002) Version 3.0