BLASTOMYCOSIS CASE WORKSHEET

INSTRUCTIONS: Enter responses in WEDSS or fax completed worksheet to the Bureau of Communicable Diseases at (608) 261-4976 or submit with Wisconsin Division of Public Health, Acute & Communicable Disease Case Report, F-44151.
*All information in red is essential for case classification.

DEMOGRAPHIC INFORMATION

Patient Name *(last, first, middle initial)*

Parent Name *(if patient is a minor)*

Date of Birth	Sex	Pregnant at diagnosis?
	☐ Male ☐ Female	☐ Yes ☐ No Due Date:

Street Address

City	Zip Code	County

Telephone: Home	Work	Cell

Occupation	Employer Location

Race ☐ White ☐ Black ☐ Native American/Native Alaskan ☐ Asian *(specify)*: _____
☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____

Ethnicity ☐ Hispanic ☐ Non-Hispanic

SYMPTOM AND SIGNS HISTORY

History from: ☐ Physician or chart/medical record ☐ Patient or relative ☐ Both

Onset date of first symptoms: _____ or ☐ Asymptomatic

Symptoms or signs *(check all that apply)*

☐ Cough	☐ Headache	☐ Fever	☐ Shortness of breath
☐ Coughing up blood	☐ Back pain	☐ Chills	☐ Joint pain
☐ Single skin lesion	☐ Chest pain	☐ Night sweats	☐ Muscle pain/aches
☐ Multiple skin lesions	☐ Poor appetite	☐ Weight loss	☐ Bone pain
☐ Fatigue	☐ Other _____		

Was the patient ever diagnosed with pneumonia or other respiratory disease within one year prior to developing current symptoms? ☐ Yes ☐ No

Did the patient's illness progress to ARDS (acute respiratory distress syndrome)? ☐ Yes ☐ No

Duration of disease *(check one)*

☐ Acute Infection (symptoms present for less than a month before being tested for blastomycosis)
☐ Chronic Infection (symptoms present for more than a month before being tested for blastomycosis)

Site of disease *(check one)*

☐ Pulmonary (disease present only in lungs)
☐ Extra-pulmonary (no current or undiagnosed past disease in lungs)
☐ Disseminated (both pulmonary and extra-pulmonary locations)

If disseminated or extra-pulmonary, which sites besides the lungs were affected *(check all that apply)*

☐ Skin ☐ Bone ☐ CNS ☐ Eye ☐ Other: _____

CLINICAL INFORMATION

What type of medical care was sought? *(check all that apply)*

Outpatient	Inpatient
☐ Clinic #1 Date(s) _____ Doctor _____ Phone _____ Clinic name _____	☐ Hospital #1 Date(s) _____ Doctor _____ Phone _____ Hospital name _____ Was the patient ever on a ventilator? ☐ Yes ☐ No
☐ Clinic #2 Date(s) _____ Doctor _____ Phone _____ Clinic name _____	☐ Hospital #2 Date(s) _____ Doctor _____ Phone _____ Hospital name _____ Was the patient ever on a ventilator? ☐ Yes ☐ No

*If patient was seen at more than two hospitals or clinics please provide the name of the other hospitals or clinics and the dates seen in comments sections at the end of this form.

Which medication(s) was the patient prescribed to treat the blastomycosis: *(check all that apply)*

☐ Itraconazole (Sporanox®) ☐ Amphotericin B ☐ Fluconazole (Diflucan®) ☐ Other: _____

What was the duration prescribed? _____

Outcome ☐ Alive, include recovery date if symptoms have resolved: _____

☐ Deceased due to blastomycosis on: _____

☐ Deceased due to other cause on: _____ Cause: _____

DIAGNOSTIC INFORMATION

Microscopy *(smear or wet prep)* ☐ Yes ☐ No

Date collected: _____

Specimen(s): _____

Lab: _____

Result for *Blastomyces*: ☐ Positive ☐ Negative

Serology ☐ Yes ☐ No

Date collected: _____

Lab: _____

☐ AGID ☐ ELISA ☐ CF

Result: ☐ Positive ☐ Negative Titer: _____

Culture ☐ Yes ☐ No

Date collected: _____

Specimen(s): _____

Lab: _____

Result for *Blastomyces*: ☐ Positive ☐ Negative

DNA Probe/PCR:

☐ Positive ☐ Negative ☐ Not performed

Urine Antigen ☐ Yes ☐ No

Date collected: _____

Specimen: _____

Lab: _____

Result for *Blastomyces* antigen: ☐ Positive ☐ Negative

Antigen level: _____

Histopathology ☐ Yes ☐ No

Date collected: _____

Specimen(s): _____

Lab: _____

Result for *Blastomyces*:

☐ Positive ☐ Negative

Comments: _____

Additional tests to rule out other fungal infections

Date of collection: _____

Specimen: _____

Lab: _____

Test: _____

Result: _____

Radiology *(check all that apply)*

☐ X-ray Date:_____
Imaged area: ☐ Chest ☐ Extremity ☐ Spine ☐ Other
Comments:_____

☐ CT Date:_____
Imaged area: ☐ Chest ☐ Extremity ☐ Spine ☐ Other
Comments:_____

☐ MRI Date:_____
Imaged area: ☐ Chest ☐ Extremity ☐ Spine ☐ Other
Comments:_____

☐ Other: Date:_____
Imaged area: ☐ Chest ☐ Extremity ☐ Spine ☐ Other
Comments:_____

RISK FACTORS

Did patient have any of the following chronic/immunosuppressive medical conditions? *(check all that apply)*

☐ COPD ☐ Diabetes ☐ Cancer ☐ Rheumatoid arthritis ☐ Organ transplant ☐ Steroid treatment ☐ Asthma
☐ Asplenia ☐ Other: _____

Is the patient a smoker or has the patient ever smoked (including but not limited to cigarettes, cigars, pipe)? *(check one)*

☐ Smoker at time of diagnosis ☐ Smoked prior to diagnosis ☐ Never smoked

For how many years? _____ Quantity smoked per day (i.e. number of packs or cigars)? _____

Has anyone else in the patient's household been diagnosed with blastomycosis? ☐ Yes ☐ No

Who/When: _____

Has anyone else that patient knows been recently diagnosed with blastomycosis? ☐ Yes ☐ No

Who/When: _____

Has patient owned a dog that was diagnosed with blastomycosis? ☐ Yes ☐ No ☐ Does not own a dog

When was the diagnosis made? (Date, or season and year): _____

Veterinarian's name: _____ Telephone: _____

EXPOSURE HISTORY – Outdoor activities

Did the patient participate in any of the following recreational outdoor activities during the past 3 months (90 days) before onset of illness? Provide date and specific location information for all yes responses. Y=Yes N=No U=Unknown

Y	N	U		
__			Hunting	When/Where: _____
			Fishing from shore	When/Where: _____
			Visiting a cabin	When/Where: _____
			Camping	When/Where: _____
			Hiking/cross country running	When/Where: _____
			Trail biking	When/Where: _____
			ATV usage	When/Where: _____
__			Visiting parks	When/Where: _____
			Kayaking, canoeing, tubing	When/Where: _____
	__		Other: _____	When/Where: _____

EXPOSURE HISTORY – Disrupted earth

Was the patient exposed to disturbed earth from any of the following activities during the 3 months (90 days) before onset of illness? Provide date and specific location information for all yes responses. Y=Yes N=No U=Unknown

Y	N	U		
			Wood/brush cutting	When/Where: _____
			Excavation	When/Where: _____
			Gardening/landscaping	When/Where: _____
			Mulch exposure	When/Where: _____
			Occupational exposures	When/Where: _____
			Construction (road/structural)	When/Where: _____
			Lawn care (raking, mowing)	When/Where: _____
			Composting	When/Where: _____
			Other: _____	When/Where: _____

Did patient travel in-state or out-of-state during the 3 months before the onset of illness? ☐ Yes ☐ No

When/Where _____

When/Where _____

Does patient live on or near a lake, river, stream, or wetland? ☐ Yes ☐ No

If yes, what is the name of the body of water? _____

If yes, how far away? ☐ Less than 100 feet ☐ Less than ¼ mile ☐ Less than 1 mile ☐ Greater than 1 mile

Notes/Remarks:

Clear Form