



Monkeypox Case Investigation Form Patient Under Investigation (PUI) Short Form

Local health departments should submit this report to the regional health department. Regional health departments should email this report to EAIDUMonitoring@dshs.texas.gov

Form with fields: Patient's Name, Address, City, County, State, Date of Birth, Home Phone, Cell Phone, Email

Form with fields: Date of Report, City, County, State, Investigator's name, Phone, Email, Investigation Start Date, Physician's name, Phone/Pager, Reporter's name, Phone, Email

PATIENT INFORMATION section with fields for Sex, Age, Residency, Race, Hispanic, Occupation, Living Situation, Immunocompromising conditions, Vaccination

CLINICAL PRESENTATION section with fields for Date of symptom onset, Hospitalized, Facility Name, Symptoms, Rash onset, Rash location, Lesion distribution, Lesion stage, Lesion size, Lesion depth, Lesion definition, Lesion umbilication

If possible, please provide photos to help characterize the lesion development and distribution.

EPIDEMIOLOGICAL EXPOSURES

In the 21 days before symptom onset, did the patient (*mark all that apply*):

Have close contact with a known monkeypox case?

If Yes, date(s) of contact with known monkeypox case: ____/____/____

Have contact with one or more persons with similar symptoms?

If Yes, complete the table on page 3. Print extra pages, if necessary.

Have close contact with any exotic pets or animals?

If Yes, date(s) of contact with animal(s): ____/____/____

If Yes, what type(s) of animals: Prairie Dog Rabbit Rope Squirrel Gambian Rat Wallaby African Tree Squirrel

Other: _____

If Yes, what type of contact? Bite Petting/handling Other: _____

If Yes, did the animal appear sick? Yes No Unknown

Have any sexual encounters?

If Yes, was the encounter(s) with: Any Male(s) Any Female(s) Any Non-binary Person(s)

If Yes, date(s) of sexual contact: ____/____/____

If Yes, briefly describe the nature of the encounter(s): _____

Have a history of travel? Yes No Unknown

Destination (city, state, country)	Arrival Date	Departure Date	Reason for Travel	Mode of Travel	Travel Details (e.g., flight number, seat number)
	____/____/____	____/____/____			
	____/____/____	____/____/____			
	____/____/____	____/____/____			

ILL CONTACTS

Contact # _____

Name:	Gender:	Age:	Relationship:	Home Phone:	Cell Phone:
Date of First Contact with Patient:	Diagnosis (if known):	Recent Travel? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Travel Details (if applicable)	
What type of contact did the patient have with this contact?					
<input type="checkbox"/> Caregiving <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Shared Food, Utensils, or Dishes <input type="checkbox"/> Shared Clothing <input type="checkbox"/> Shared Towels or Bedding <input type="checkbox"/> Shared Bathroom <input type="checkbox"/> Unknown <input type="checkbox"/> Face-to-Face Contact, specify length of time: _____ <input type="checkbox"/> Transit Trip, specify length of time: _____ <input type="checkbox"/> Other: _____					

Contact # _____

Name:	Gender:	Age:	Relationship:	Home Phone:	Cell Phone:
Date of First Contact with Patient:	Diagnosis (if known):	Recent Travel? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Travel Details (if applicable)	
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