

LYME DISEASE CASE REPORT FORM

Form Approved
OMB No. 0920-0009
Expiration Date
12-92

Patient's last name _____ First name _____ Tele.No. (____) _____

Address _____ City _____

Detach before sending to CDC

State _____ County _____ Zip _____

Age (yrs.) _____ Sex M F Unspec. Race Amer. Indian/Eskimo Asian/Pacific Isl. Black White Unknown Ethnicity Hispanic Non Hisp. Unknown

SYMPTOMS AND SIGNS OF CURRENT EPISODE (PLEASE MARK EACH QUESTION):

DERMATOLOGIC:

Erythema migrans (physician diagnosed EM at least 5 cm in diameter)? _____ [Y] [N] [?]

RHEUMATOLOGIC:

Arthritis characterized by brief attacks of joint swelling? _____ [Y] [N] [?]

NEUROLOGIC:

Bell's palsy or other cranial neuritis? _____ [Y] [N] [?]

Radiculoneuropathy? _____ [Y] [N] [?]

Lymphocytic meningitis? _____ [Y] [N] [?]

Encephalitis/Encephalomyelitis? _____ [Y] [N] [?]

CSF tested for antibodies to B. burgdorferi? _____ [Y] [N] [?]

Antibody to B. burgdorferi higher in CSF than serum? _____ [Y] [N] [?]

CARDIOLOGIC:

2nd or 3rd degree atrioventricular block? _____ [Y] [N] [?]

Other clinical: _____

Date of onset of first symptoms: / / mo dy yr Date of diagnosis: / / mo dy yr Date of report to health agency / / mo dy yr

OTHER HISTORY

Was the patient hospitalized for the current episode? _____ [Y] [N] [?]

Name of antibiotic(s) used this episode? _____ Use in days _____

Was the patient pregnant at the time of illness? _____ [Y] [N] [?]

Where was the patient most likely exposed? County _____ State _____

LABORATORY RESULTS

	Positive	Negative	Equivocal	Not done/Unknown
Serologic test results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culture results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physician's name _____ Person completing form _____
(if not the same)

Address _____ Address _____

Telephone Number (____) _____ Telephone Number (____) _____

FOR INTERNAL USE ONLY

State ID No.

CDC ID No.

Date Reported to CDC / / mo dy yr

LYME DISEASE CASE REPORT FORM
CDC 52.60 REV. 1-91

This report is authorized by law (Public Health Service Act, 42 USC 241). While your response is voluntary, your cooperation is necessary for the understanding and control of this public health problem. Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to PHS Reports Clearance Officer; ATTN: PRA; Hubert H. Humphrey Bldg, Rm 721-B; 200 Independence Ave., SW; Washington, DC 20201, and to the Office of Management and Budget; Paperwork Reduction Project (0920-0009); Washington, DC 20503.

