LYME DISEASE CASE REPORT FORM

Patient Information

First Name: ______________________ **Last Name:** ______________________

Address: ____
Street City State Zip Code

Date of Birth: Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]

Sex: ❑ Male ❑ Female ❑ Unspecified

Date of Onset: Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]

Date of Diagnosis: Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]

Symptoms and Signs of Current Episode (Select all that apply)

- ❑ Erythema migrans
- ❑ Atrioventricular block
- ❑ Bell's Palsy
- ❑ Other cranial neuritis
- ❑ Encephalitis
- ❑ Encephalomyelitis
- ❑ Arthritis
- ❑ Lymphocytic meningitis
- ❑ Radiculoneuropathy
- ❑ Other____________________

Does the patient recall a tick bite? ❑ Yes ❑ No

Did the patient travel in the 30 days prior to onset? ❑ Yes ❑ No

If yes, where? ______________________

Are diagnostic laboratory tests pending? ❑ Yes ❑ No

Were antibiotics prescribed? ❑ Yes ❑ No

If yes, what was prescribed and for how long? ______________________

Physician Information

Physician Name: ______________________ **Practice:** ______________________

Phone #: ______________________