



Trichuriasis Investigation Form
Patient's name:
Address:
City: County: Zip:
Phone 1: Phone 2:
Date of birth: Age: Sex:
Race:
Hispanic:
Patient Occupation:
Parent/guardian's name
Country of origin: Date of arrival in US:
NBS Patient ID:
Reported by:
Agency:
Phone: Date reported:
Investigated by:
Agency:
Phone:
Email:
Investigation start date:
Investigation completed date:

CLINICAL DATA
Date of symptom onset: Illness end date: Did patient die?
Signs and symptoms (Check all that apply):
Did the patient receive treatment?
Physician's name: Physician's phone:
Was the patient hospitalized?
If yes, Date of admission: Date of discharge:

LABORATORY
Microscopic identification of Trichuria eggs or adult worms in feces (O&P).
Identification of adult Trichuria worms during sigmoidoscopy, proctoscopy, or colonoscopy.
Identification of adult worms on prolapsed rectal mucosa.

CONTACTS
How many people live in the patient's household?
Has anyone else in the household been treated for a helminthitic/parasitic infection?
Are there any contacts ill with similar illness?
Last name: First/ MI Age: Sex:
Relationship to case: Onset date: Type of infection/symptoms:
Contact info same as case? Address: Phone:

Trichuriasis Investigation Form Continued

NBS Patient ID:

EXPOSURE HISTORY

Has the patient or any member of the household lived or traveled internationally in the last 2 years? Yes No Unknown

If yes, where and when?

Country Visited	Dates Traveled	Traveler
		<input type="checkbox"/> Patient <input type="checkbox"/> Household member
		<input type="checkbox"/> Patient <input type="checkbox"/> Household member
		<input type="checkbox"/> Patient <input type="checkbox"/> Household member
		<input type="checkbox"/> Patient <input type="checkbox"/> Household member

Does the patient visit, work, or live on a farm? Yes No Unknown

If yes, where? _____

Does the patient have contact with soil (e.g. gardening, landscaping, child playing outside in dirt) either for work or recreation?

Yes No Unknown If yes, describe: _____

What type of plumbing system exists in the patient's home?

City sewage disposal Septic Tank Other, please describe: _____

Near the patient's home, work, or school are there areas potentially contaminated with human waste (e.g. outhouses, contaminated bodies of water)? Yes No Unknown

If Yes, please describe: _____

COMMENTS