CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting monkeypox. Report to local health department within one working day.

DISEASE BEING REPORTED: MONKEYPOX

Please write all dates as (mm/dd/yyyy)

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Country of Birth*** | ***Primary Language*** ☐ English ☐ Spanish Other:

Birth Date *(mm/dd/yyyy)* | ***Age***

Current Gender Identity

- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transfemale
- ☐ Genderqueer or non-binary
- ☐ Identity or not listed (specify):_____
- ☐ Declined to answer

Sex Assigned at Birth

☐ Male ☐ Female ☐ Declined to answer

Pregnant?

☐ Yes ☐ No ☐ Unknown

If Yes, Est. Delivery Date: _____

Currently breastfeeding?

☐ Yes ☐ No ☐ Unknown

Sexual Orientation

- ☐ Heterosexual or straight
- ☐ Bisexual
- ☐ Gay, lesbian, or same gender loving
- ☐ Orientation not listed (specify):_____
- ☐ Questioning / unsure / client doesn't know
- ☐ Declined to answer

Gender(s) of sex partners (check all that apply)

- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transfemale
- ☐ Genderqueer or non-binary
- ☐ Identity or not listed (specify):_____
- ☐ Declined to answer

Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)

- ☐ African-American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian *(check all that apply)*
  - ☐ Asian Indian ☐ Hmong ☐ Thai
  - ☐ Cambodian ☐ Japanese ☐ Vietnamese
  - ☐ Chinese ☐ Korean ☐ Other (specify):
  - ☐ Filipino ☐ Laotian _____
- ☐ Pacific Islander *(check all that apply)*
  - ☐ Native Hawaiian ☐ Samoan
  - ☐ Guamanian ☐ Other (specify): _____
- ☐ White
- ☐ Other (specify) _____ ☐ Unknown

Close contact with a laboratory confirmed monkeypox case?

☐ Yes ☐ No ☐ Unknown

If Yes, type of contact:

- ☐ Household contact
- ☐ Community contact
- ☐ Any healthcare contact
- ☐ Workplace contact

Additional Contact Details

Congregate setting *(check if applies)*

- ☐ Staff ☐ Resident ☐ Shelter
- ☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Clinic
- ☐ Correctional Facility ☐ Hospital-Based Facility ☐ Unknown
- ☐ Other (specify):

Occupation or Job Title

☐ Healthcare worker ☐ Non-healthcare

Housing Status

☐ Stable ☐ Unstable ☐ Unknown

Name, City of Congregate Setting(s)

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Email Address: | ***Date Submitted***

REPORT TO:

City of Long Beach Department of Health & Human Services, Communicable Disease Surveillance and Control Division
2525 Grand Ave, Room 229
Long Beach, CA 90815
Phone: (562) 570-4302
STI/HIV Phone: (562) 570-4321
Fax: (562) 570-4374
Encrypted email: LBEpi@longbeach.gov

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

LONG BEACH HEALTH & HUMAN SERVICES

CONFIDENTIAL MORBIDITY REPORT - MONKEYPOX (continued)

Patient Name - Last Name	*First Name*	*MI*	*Birth Date (mm/dd/yyyy)*

MONKEYPOX - Diagnostic Testing

Name of Performing Laboratory

Specimen Collection Date

Performing lab specimen IDs (i.e. a laboratory generated number that identifies the specimen related to this test)

Monkeypox/Orthopox virus test result:

☐ OPX+ ☐ OPX- ☐ Inconclusive ☐ Not done

☐ MPX+ ☐ MPX- ☐ Inconclusive ☐ Not done

Test result date:

Clinical Information

Monkeypox Symptoms (check all that apply)

☐ Fever ☐ Abdominal Pain ☐ Rectal Bleeding ☐ Vomiting or Nausea

☐ Rash ☐ Headache ☐ Pus or blood on stools ☐ Myalgia (muscle aches)

☐ Rectal Pain ☐ Chills ☐ Enlarged Lymph Nodes ☐ Tenesmus/urgency to defecate

☐ Proctitis ☐ Pruritis (itching) ☐ Conjunctivitis ☐ Malaise (general feeling of illness or weakness)

Date of first symptom onset:

Did you have a rash during the course of your illness?

☐ Yes ☐ No ☐ Unknown

If yes, where on your body is the rash? (choose all that apply)

☐ Mouth ☐ Arms ☐ Soles of feet

☐ Lips or oral mucosa ☐ Legs ☐ Genitals

☐ Trunk ☐ Palms of hands ☐ Perianal

☐ If other, please specify:

Any evidence of ocular involvement (ocular lesions, keratitis, conjunctivitis, eyelid lesions)?

Diagnosis History

Has this individual been diagnosed with any acute infections other than monkeypox during this current illness/or within the last three weeks? (e.g., gonorrhea, chlamydia, syphilis, HSV, other STI, varicella)

☐ Yes ☐ No ☐ Unknown

If HIV positive, was the individual's viral load undetectable when it was last checked?

☐ Yes ☐ No ☐ Unknown

What is the individual's HIV status?

☐ HIV Positive ☐ HIV Negative

☐ Unknown

Does the individual have any known immunocompromising conditions (excluding HIV) or take immunosuppressive medications? Immunocompromising conditions can include organ transplants, stem cell transplants, and active cancer. Certain medicines like chemotherapy, biologic therapies, and steroids can also weaken the immune system.

If yes, describe the associated condition or treatment

History of Hospitalization

Has the individual been hospitalized for monkeypox?

☐ Yes ☐ No ☐ Unknown

If yes, what was the reason for the hospitalization? (choose all that apply)

☐ Breathing problems requiring mechanical ventilation

☐ Breathing problems not requiring mechanical ventilation

☐ Treatment for secondary infection

☐ Pain control

☐ Disseminated disease

☐ Exacerbation of underlying condition (e.g. autoimmune or skin condition)

☐ Other

If other, specify:

Is the individual currently receiving HIV pre-exposure prophylaxis?

☐ Yes ☐ No ☐ Unknown

Individual's most recent admission date to the hospital for the condition covered by the investigation:

Individual's most recent discharge date from the hospital for the condition covered by the investigation:

Please use this space to include any additional notes or comments

Contact Type

☐ Shared food, utensils, or dishes

☐ Shared towels, bedding, or clothing

☐ Shared bathrooms (toilets, sinks, showers)

☐ Health care worker

☐ Identified air contact

☐ Other

☐ Providing care to case – home setting

☐ Indirect contact (e.g., shared sexual partners)

☐ Sexual (e.g., vaginal, oral, or anal sex) or intimate contact (e.g., cuddling, kissing, touching partner's genitals or anus, or sharing sex toys)

☐ Shared transportation (e.g., carpooling, riding a bus, rising a motorcycle, using a taxi, using Uber) (specify mode of transportation)

☐ Face-to-face contact, not including intimate contact (being within six feet for more than three hours of an unmasked case-patient without wearing, at a minimum, a surgical mask

☐ If other, please specify:

Travel to or reside in an area with sustained, ongoing, community transmission of monkeypox?

Vaccination History

Did the individual ever receive a vaccine against smallpox or monkeypox?

☐ Yes ☐ No ☐ Unknown

If yes, please give the reason, date, and manufacturer, and dose number for each vaccine received:

	Reason	Vaccine Date	Vaccine Manufacturer	Dose Number
Vaccine 1	☐ Pre-exposure ☐ Post-exposure ☐ Routine pre-exposure ☐ Unknown		☐ MIP ☐ BN ☐ WAL ☐ Jynneos	
Vaccine 2	☐ Pre-exposure ☐ Post-exposure ☐ Routine pre-exposure ☐ Unknown		☐ MIP ☐ BN ☐ WAL ☐ Jynneos	
Vaccine 3	☐ Pre-exposure ☐ Post-exposure ☐ Routine pre-exposure ☐ Unknown		☐ MIP ☐ BN ☐ WAL ☐ Jynneos	

Additional remarks:

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