mpox Investigation Form

Health Protection Agency

Male', Republic of Maldives

HPA-SUR-*U000211*-F-2024-02

SECTION 1: PATIENT IDENTITY

1. Full Name
2. Date of birth ___/___/___
3. Age in days (neonate) ____Age in months (Infant) ____ Age in years (others) ___
4. Gender ☐ M ☐ F
5. Permanent Address _____Atoll _____ Island_____
6. Current Address _____Atoll _____ Island_____
7. Nationality _____
8. Occupation of the patient_____

SECTION 2: CLINICAL HISTORY / PRESENTATION

1. Date of onset of symptoms: __/___/___
2. Address of Onset _____Atoll _____ Island_____
   a. Did the patient travel anytime in the three weeks before becoming ill? ☐ YES ☐ NO
   b. If yes, indicate the places (1) _____ (2) _____
      (3) _____ Others: _____
   c. Did the patient travel during illness? ☐ YES ☐ NO
   d. If Yes, indicate the places (1) _____ (2) _____
      (3) _____ Others: _____
3. Does the patient have a cutaneous eruption/rash? ☐Yes ☐ No
   a. If yes, date of onset for the rash: ___/___/___
4. Did the patient have fever? ☐ YES ☐ NO
   a. If yes, date of onset for the fever: ___/___/___ Grade __ °C or ___ ° F
5. At Present,
   a. Are the lesions in the same state of development on the body? ☐ YES ☐ NO
   b. Are all of the lesions the same size? ☐ YES ☐ NO
   c. Are the lesions deep and profound? ☐ YES ☐ NO
6. Does or did the patient have any of the following symptoms (check all that apply)

Headache	☐ Yes ☐ No	Lesions that itch	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Muscle pain (myalgia)	☐ Yes ☐ No
Lymphadenopathy, inguinal	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No
Lymphadenopathy, axillary	☐ Yes ☐ No	Conjunctivitis	☐ Yes ☐ No
Lymphadenopathy, cervical	☐ Yes ☐ No	Sensitivity to light	☐ Yes ☐ No
Chills or sweats	☐ Yes ☐ No	Is the patient bedridden?	☐ Yes ☐ No
Sore throat when swallowing	☐ Yes ☐ No	Oral ulcers	☐ Yes ☐ No
Vomiting/nausea	☐ Yes ☐ No		

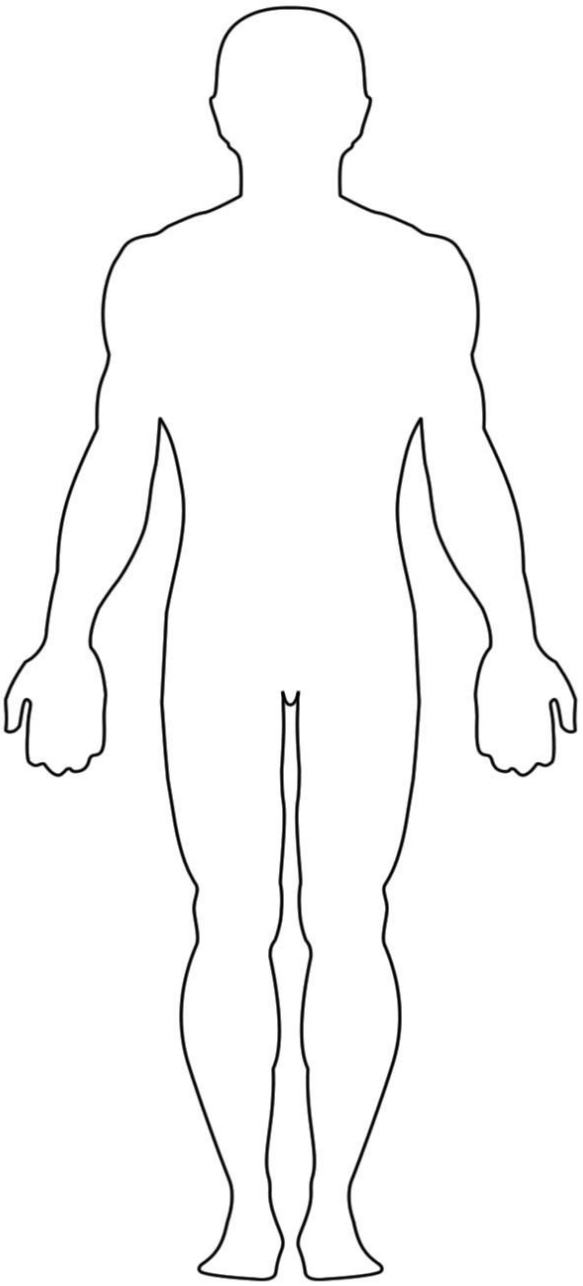
7. If female, Pregnancy status: ☐ Pregnant ☐ Not pregnant
8. HIV status: ☐ Negative ☐Positive ☐ Unknown
9. Any other known medical condition (Please state)

   _____

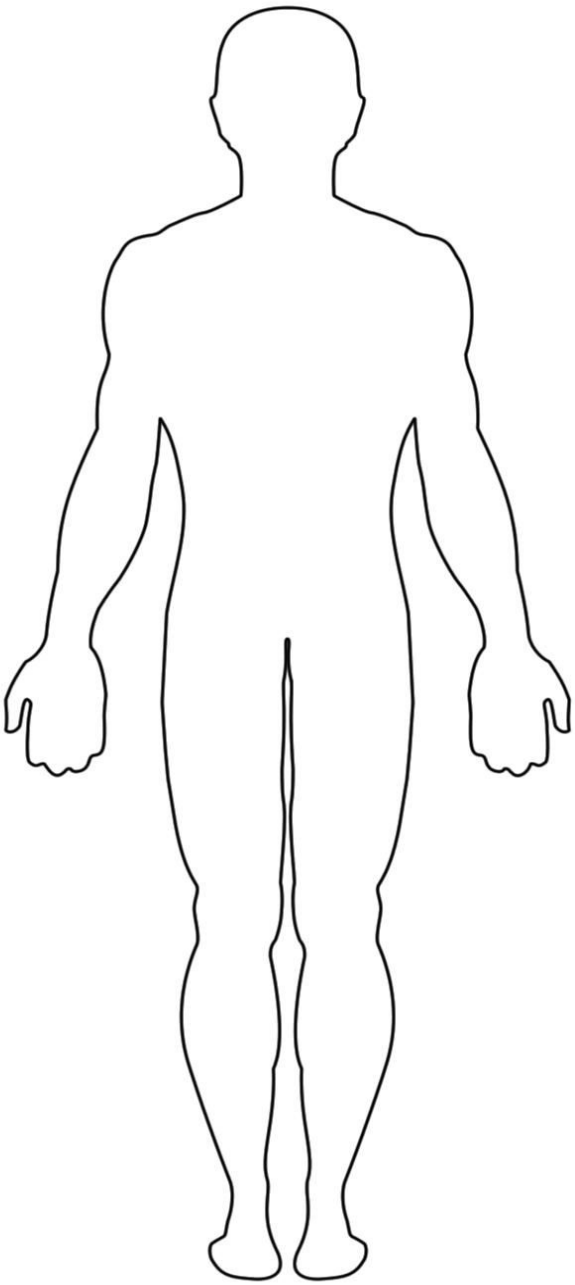
10. Localization of the lesions

☐ Face	☐ Eyes	☐ Legs	☐ Soles of the feet
☐ Perianal	☐ Back	☐ Chest	☐ Palms of the hands
☐ Arms	☐ Abdomen	☐ Genital	☐ All over the body
☐ Neck	☐ Other _____		

FRONT



BACK



* Send Photos of the lesions when sending this form

11. Did the patient develop ulcers? ☐ YES ☐ NO

SECTION 4: EXPOSURE

1. During the three weeks preceding the onset of symptoms, did the patient have contact with one or more persons who had similar symptoms? ☐ Yes ☐ No
    a. If yes, respond to the following questions concerning these additional ill people (indicate all of the ill people).
        i. Full name _____
        ii. Relationship with the patient _____
        iii. First date of contact with the ill person ___/___/___
2. Did the patient touch a domestic or wild animal during the three weeks preceding symptom onset? ☐ Yes ☐ No
    a. If Yes, what kind of animal_____
    b. Date of contact ___/___/___
    c. Type of contact (check all that apply)

☐ Rodents alive in the house ☐ Dead animal found in the forest
☐ Alive animal living in the forest ☐ Animal bought for meat Others:

SECTION 5: LABORATORY

1. Was a specimen collected? Yes No
    a. If Yes, date and Time ___/___/___ - ___: ___
    b. Type:

☐ Nasal Swab ☐ Throat Swab ☐ Swabs from Pustule
☐ Crusts / scabs ☐ Swabs of vesicular lesions ☐ Swabs of Maculopapular lesions
☐ Blood ☐ Others _____

SECTION 6: UPDATE ON THE HOSPITAL INFORMATION

2. Was the patient sent to a hospital? ☐ Yes ☐ No
3. Was the patient admitted in the isolation ward? ☐ Yes ☐ No
    a. If Yes, name of hospital_____ Hospitalization date ___/___/__
    b. Date of discharge___/___/___OR Date of death___/___/__

SECTION 7: Notified By

Reporting Facility _____ Date of Reporting ___/___/__

Name: _____ Designation: _____ Signature: _____