Organization/Institution:_____
Date :_____/_____/_____ Interviewer:_____
Interviewer telephone number: _____ Country :_____

Leptospirosis case investigation form

General information:

Name of the interviewer: _____ Interview date: _____

Interviewer telephone number: _____

Demographic information:

Patient first name: _____ Patient last name: _____

Patient case number: _____ Patient telephone number: _____

Age: _____ Sex: M ☐ F ☐ Ethnicity: _____

Residence address: _____

Town/Village: _____ Region: _____

State/Province: _____ Country: _____

Did the patient travel to one or multiple locations in the month before the onset of symptoms?

Yes ☐ No ☐ Don't know ☐

If so, specify where:

Location 1: _____

Date of arrival: _____ Date of departure: _____

Location 2: _____

Date of arrival: _____ Date of departure: _____

Clinical information:

Date of symptoms onset: _____

Did you visit a health clinic or a hospital since the beginning of your symptoms? Yes ☐ No ☐

If so, when: _____ Name of the physician: _____

Clinical signs and symptoms:

- Fever Yes ☐ No ☐ Unknown ☐
- Chills Yes ☐ No ☐ Unknown ☐
- General malaise Yes ☐ No ☐ Unknown ☐
- Confusion Yes ☐ No ☐ Unknown ☐
- Conjunctival suffusion Yes ☐ No ☐ Unknown ☐

World Health Organization

Organization/Institution:_____

Date :_____/_____/_____ Interviewer:_____

Interviewer telephone number: _____ Country :_____

• Headache	Yes ☐	No ☐	Unknown ☐
• Neck stiffness	Yes ☐	No ☐	Unknown ☐
• Myalgia	Yes ☐	No ☐	Unknown ☐
• Jaundice	Yes ☐	No ☐	Unknown ☐
• Cough	Yes ☐	No ☐	Unknown ☐
• Dyspnea	Yes ☐	No ☐	Unknown ☐
• Hemoptysis	Yes ☐	No ☐	Unknown ☐
• Anorexia	Yes ☐	No ☐	Unknown ☐
• Nausea	Yes ☐	No ☐	Unknown ☐
• Vomiting	Yes ☐	No ☐	Unknown ☐
• Abdominal pain	Yes ☐	No ☐	Unknown ☐
• Diarrhea	Yes ☐	No ☐	Unknown ☐
• Oliguria/Anuria	Yes ☐	No ☐	Unknown ☐
• Urine color modification	Yes ☐	No ☐	Unknown ☐
• Hemorrhages	Yes ☐	No ☐	Unknown ☐
• Joint pain	Yes ☐	No ☐	Unknown ☐
• Skin rash	Yes ☐	No ☐	Unknown ☐
• Photophobia	Yes ☐	No ☐	Unknown ☐
• Other	Specify: _____		

Did you take antibiotics in the last month, either as chemoprophylaxis or for another condition?

Yes ☐ No ☐ Unknown ☐ If so, which and when: _____

Hospitalization (admitted to a health facility for at least one night): Yes ☐ No ☐

Date of admission: _____ Date of discharge: _____

Resolution of the symptoms: Yes ☐ No ☐

Date of resolution: _____

Days of work missed as a result of illness: _____

Exposure to risk factors:

_____

General:

Presence of a skin lesion/wound on the body during the past month:

Yes ☐ No ☐ Unknown ☐

Walking barefooted during the past month:

Yes ☐ No ☐ Unknown ☐

Source of drinking water:

Tap water ☐ Well water ☐ Stream water ☐ Other: _____

World Health Organization

Organization/Institution:_____
Date :_____/_____/_____ Interviewer:_____
Interviewer telephone number: _____ Country :_____
What is your current employment? _____

Animal exposure:

Do you have any domestic animal or pet at home? Yes ☐ No ☐

Dog ☐ Cat ☐ Other: _____

Did you handle any animals during the last month (apart from your domestic animal)?

Yes ☐ No ☐ Unknown ☐

If so, which animals were handled?

Cows ☐ Pigs ☐ Horses ☐ Rodents ☐ Other: _____

Types of handling (e.g. feeding, cleaning, etc.): _____

Date of the handling: _____

Were you exposed to any animals in the environment without handling them in the last month? (e.g. farm visit, animals in the neighborhood or the backyard, pest in the house, etc.)

Yes ☐ No ☐ Unknown ☐

If so, which animals were you exposed to?

Rats ☐ Mice ☐ Pigs ☐ Cows ☐ Horses ☐ Dogs ☐ Other:

Location of the exposure:

Home ☐ Neighborhood ☐ Backyard ☐ Market ☐

Work ☐ Farm ☐ Other ☐ Specify: _____

Date of this exposure: _____

To the best of your knowledge, was there any animal in your surrounding that was ill or died in the last month?

Yes ☐ No ☐ Unknown ☐

Recreational activities:

Did you practice one or several of these activities in the last month?

Canoe ☐ Kayak ☐ Rafting ☐ Swimming ☐

Running in muddy conditions ☐ Triathlon ☐ Fishing ☐

Canyoning ☐ Gardening ☐ Hunting ☐ Hiking ☐

If so, when: _____

Where was this activity taking place?

_____

World Health Organization

Organization/Institution:_____

Date :_____/_____/_____ Interviewer:_____

Interviewer telephone number: _____ Country :_____

Did you swallow some water during this activity?

Yes ☐ No ☐ Unknown ☐

In case of flood exposure:

Walking in flood water:

Yes ☐ No ☐ Unknown ☐

Swimming in flood water:

Yes ☐ No ☐ Unknown ☐

Swallowing flood water:

Yes ☐ No ☐ Unknown ☐

Exposure of a wound/cut to flood water:

Yes ☐ No ☐ Unknown ☐

Involvement in flood recovery/cleaning:

Yes ☐ No ☐ Unknown ☐

Consumption of wet food or food contaminated by flood water:

Yes ☐ No ☐ Unknown ☐

If so, please provide the date and the location of this/these exposure(s):

Date of exposure(s): _____

Location: _____

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