Questionnaire for Suspect Measles Cases  
(See Measles Investigation Summary for details)

**Case Information:**

Name: ___________________________  
Occupation: ______________________

DOB / Age: ______  
Address/Phone Number: _______________________________________________________

**Clinical Information:**

1) Did a physician diagnosis of this patient with measles? Yes_________  No_________  
If yes, date of diagnosis: __________

2) What other diagnosis are being considered? ________________________________________

3) What are the suspect case’s symptoms? *(Fill out table below)*

<table>
<thead>
<tr>
<th>Rash</th>
<th>No</th>
<th>Yes</th>
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<tbody>
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</table>

If yes, when did the rash start? ______

Describe the rash (check all that apply):

- Raised bumps
- Flat
- Fluid-filled/vesicular
- Discrete dots
- Coalescing dots
- Itchy
- Other

Where on the body did it start? __________

Where and how did the rash progress?

____________________________________

How many days did the rash last?

_____________________________________

<table>
<thead>
<tr>
<th>Fever</th>
<th>No</th>
<th>Yes</th>
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</table>

If yes, fever onset date? ______

Maximum temperature______

How many days did it last? ______

<table>
<thead>
<tr>
<th>Cough</th>
<th>No</th>
<th>Yes</th>
<th>Onset date:</th>
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</table>

<table>
<thead>
<tr>
<th>Runny nose</th>
<th>No</th>
<th>Yes</th>
<th>Onset date:</th>
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<td></td>
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<table>
<thead>
<tr>
<th>Red or itchy eyes or drainage from the eyes</th>
<th>No</th>
<th>Yes</th>
<th>Onset date:</th>
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<table>
<thead>
<tr>
<th>Pneumonia</th>
<th>No</th>
<th>Yes</th>
<th>Onset date:</th>
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<table>
<thead>
<tr>
<th>Other Symptoms</th>
<th>No</th>
<th>Yes</th>
<th>List:</th>
</tr>
</thead>
</table>
4) Was this suspect case vaccinated with MMR in the last 90 days?  
   Yes_________ No_________

5) Did suspect case take antibiotics in the last 2 weeks?  
   Yes_________ No_________  
   If yes, type of antibiotics and date first taken______________________

6) Any other new medication in last 2 weeks?  
   Yes_________ No_________  
   If yes, type of medication and date first taken______________________

7) Any known drug allergies?  
   Yes_________ No_________  
   If yes, provide details________________________________________________________

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**Immunity Status Information**

1) Was this person born in the United States?  
   Yes_________ No_________  
   If no, birth country____________________

2) Does this patient have a history of measles disease?  
   Yes_________ No_________ Not Sure___________

3) Was the patient ever diagnosed with measles by a healthcare provider in his/her lifetime?  
   Yes_________ No_________ Not Sure___________

4) Was the patient ever tested for measles immunity? *(positive IgG/immunity screen, measles, mumps, rubella for a pre-natal screen or for admission into school)*  
   Yes_________ No_________ Not Sure___________  
   *(If yes, have immunity results faxed)*

5) Was this patient vaccinated for measles (MMR, MMRV) previously?  
   Yes_________ No_________ Not Sure___________  
   If yes, complete table below and obtain a printed copied of vaccination record:

<table>
<thead>
<tr>
<th></th>
<th>Dose 1</th>
<th>Date:</th>
<th>Dose 2</th>
<th>Date:</th>
<th>Dose 3</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
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<tr>
<td></td>
<td></td>
<td>Date:</td>
<td></td>
<td>Date:</td>
<td></td>
<td>Date:</td>
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</table>

*Note: Measles vaccine doses given prior to 1968 may not be effective.*

If unknown vaccination history, can patient provide documentation of vaccination status or immunity later?  
   Yes_________ No_________ Not Sure___________

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**Exposure History**

1) Has this person traveled outside of the US (within the last 21 days)?  
   Yes_________ No_________  

2) Has this person traveled outside of Colorado (within the last 21 days)?  
   Yes_________ No_________  

3) Has this person traveled through an airport or any place where large groups of people from various areas may be within the last 21 days?  
   Yes_________ No_________
4) Has this person had visitors from foreign countries within the last 21 days?
   Yes__________ No__________

5) Does this person know anyone with similar symptoms?
   Yes__________ No__________

If yes to any of the above, provide details:
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**Laboratory Information**

1) Were specimens collected for testing?  Yes__________ No__________
   If yes, complete table below:

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Test Ordered</th>
<th>Date Collected</th>
<th>Time Collected</th>
<th>Lab where specimen is being sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specimen 1</td>
<td>□ IgM □ IgG □ PCR □ Culture □ Other__________</td>
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<tr>
<td>Specimen 2</td>
<td>□ IgM □ IgG □ PCR □ Culture □ Other__________</td>
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<tr>
<td>Specimen 3</td>
<td>□ IgM □ IgG □ PCR □ Culture □ Other__________</td>
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<tr>
<td>Specimen 4</td>
<td>□ IgM □ IgG □ PCR □ Culture □ Other__________</td>
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</tr>
<tr>
<td>Specimen 5</td>
<td>□ IgM □ IgG □ PCR □ Culture □ Other__________</td>
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</table>
If no, arrange and obtain appropriate diagnostic specimens:
- Serum in a serum separator tube for measles IgM and IgG testing. Specimen should be collected within 3-28 days after rash onset if possible. If serum collected prior to 72 hours days after rash onset, a second serum sample for IgM may need to be obtained.
- NP swab or aspirate/ throat swab for PCR
- Urine sample for PCR
- Call State/Regional Epi to coordinate lab testing
- See measles specimen collection instructions: http://www.cdc.gov/measles/lab-tools/rt-PCR.html#shipping

**STOP:** Consult with CDPHE on likelihood of confirmed case before proceeding with a contact investigation.

**Contact Information**

1) Who is in the patient’s household? (Be sure to identify contacts with a high risk occupation such as healthcare and childcare workers.)

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB/Age</th>
<th>Occupation</th>
<th>Immunity Status</th>
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2) Did the patient visit a healthcare facility while infectious?
   Yes______________ No___________
   If yes, day and time__________________________
   Name of facility, physician name, location, and phone number:___________________________________________
   Length of time in facility/waiting room__________________________________________

3) Does this person have any close contacts who are infants < 12 months, pregnant women, or immunocompromised persons/taking immunosuppressive medications?
   Yes______________ No___________
   If yes, provide details (Name/contact information):
   ____________________________________________________________________________
   ____________________________________________________________________________

4) If measles is suspected, identify all contacts (4 days prior and 4 days after rash onset) that had direct exposure to the case (were in the same room, home, school, work, airplane, etc.) or were in these areas up to 2 hours after the case was present.

For additional guidance such as a Measles Investigation Summary, Measles Management Timeline, and Communicable Disease Manual Measles Chapter, see http://www.colorado.gov/cs/Satellite/CDPHE-DCEED/CBON/1251611026109