SALUD Secretaría de Salud | IMSS | ISSSTE | PEMEX | SEDENA Secretaría de la Defensa Nacional | SEMAR Secretaría de Marina | SNDIF Sistema Nacional DIF | INPI Instituto Nacional de los Pueblos Indígenas

Epidemiologic study of suspected viral respiratory disease

GENERAL INFORMATION

Name of medical unit:

Date of registration in the platform: dd/mm/yyyy Platform number:

Last Name: Second Last Name: Name(s):

Date of birth: Day: Month: Year: CURP:

Sex: Man: Woman: Pregnant patient: Yes No Months of pregnancy: Patient in puerperium Yes No Days of puerperium

Nationality: Mexican: Foreigner: Migrant: Yes No Country of nationality: Country of origin:

Visited countries in the last three months: 1 2 3 Other: Date of entry into Mexico:

Country of birth: Place of birth (state):

Place of residency (state): Municipality of residence:

Locality:

Street: Number:

Between streets: &

Suburb: PC: Telephone:

Indigenous self-identification: Yes No Speaker of indigenous language: Yes No

Occupation:

Is the patient affiliated to an educational institution?

CLINICAL DATA

Admitted to (service): Type of attention: 1=Ambulatory 2=Hospitalization

Date of admission: dd/mm/yyyy Date of symptom onset: dd/mm/yyyy

Since the onset of symptoms, has the patient…

…had any of the following signs or symptoms?

	Yes	No
Sudden onset of symptoms		
Fever		
Cough		
Headache		
Shortness of breath		
Irritability		
Chest pain		
Chills		
Sore throat		
Myalgias		
Arthralgias		
Anosmia		
Dysgeusia		
Rhinorrhea		
Conjunctivitis		

Comorbidities

	Yes	No
Diabetes		
COPD		
Asthma		
Immunosuppression		
Hypertension		
HIV/AIDS		
Cardiovascular disease		
Obesity		
Chronic kidney disease		
Smoker		
Other		

Specify any others:

Other symptoms	Yes	No
Abrupt deterioration		
Diarrhea		
Polypnea		
Abdominal pain		
Vomit		
Cyanosis		

Probable diagnosis: 1=Influenza-like illness (ILI)* 2=Severe acute respiratory infection (SARI)

*ILI is a mild respiratory disease

TREATMENT

Since the onset of symptoms, has the patient…

…been treated with antipyretics? Yes / No

…been treated with antivirals? Yes / No

If the answer was yes:

Specify the antiviral: ____ 1=Amantadine 2=Rimantadine 3=Oseltamivir 4=Zanamivir 5=Other, specify: ____

When was the antiviral medication started? ____ dd/mm/yyyy

In the medical unit…

…were antibiotics started? Yes / No

…were antivirals started? Yes / No

Specify the antiviral: ____ 1=Amantadine 2=Rimantadine 3=Oseltamivir 4=Zanamivir 5=Other, specify: ____

EPIDEMIOLOGICAL HISTORY

Has the patient had any contact with persons with respiratory disease in the last two weeks? Yes / No

During the weeks prior to symptom onset did the patient have contact with:

	Yes	No
Birds:		
Swine:		

Other animals: ____

Recent travels in the 7-day period before the onset of signs/symptoms: Yes / No

Country: ____ City: ____

Did the patient receive last-year influenza vaccination? Yes / No

Date of vaccination: ____ dd/mm/yyyy

LABORATORY

Was a sample for testing obtained? Yes / No

Laboratory that will be processing the sample: ____

Site of sample: ____ 1=Pharyngeal swab 2=Nasopharyngeal swab 3=Bronchoalveolar lavage 4=Pulmonary biopsy

Date sample was obtained: ____ dd/mm/yyyy

Result: ____

FOLLOW-UP

Follow-up status: ____ 1=Discharged 2=Undergoing treatment/Referred/Domiciliary follow-up/End of follow-up 3=Severe case 4=Mild case 5=Death*

In case of discharge: Indicate cause of discharge: ____ 1=Improvement 2=Curation 3=Voluntary 4=Transferred

Has the patient been admitted to an ICU at any moment of the disease? Yes / No

Has the patient been put on invasive mechanical ventilation at any moment of the disease? Yes / No

Has the patient been diagnosed with pneumonia at any moment of the disease? Yes / No

Date of discharge: ____ dd/mm/ yyyy

Specify if this is a positive COVID-19 case by association or clinical-epidemiological ruling: *

** Mark with an X only one of the following options*

a. Confirmed COVID-19 by clinical-epidemiological association ____

b. Confirmed COVID-19 by clinical-epidemiological ruling (applies only for deaths) ____

c. No (none of the previous options) ____

Death: Date of death: ____ dd/mm/yyyy

Death Certificate (number): ____ ***Death due to influenza or COVID-19** Yes / No

*Attach a copy of the death certificate if the patient met criteria for suspected viral respiratory disease case

Name and position of person registering data

____

____

Name and position of authorizing person

____

____

Date of elaboration: ____ dd/mm/yyyy