Mpox (Monkeypox)
Intake & Investigation Form
Rev. 6/24

PATIENT DEMOGRAPHICS

Name (last, first): ______________________________
Address (mailing): ______________________________
Address (physical): ______________________________
City/State/Zip: ______________________________
Phone (home): ______________ **Phone** (work/cell) : ______________
Email: ______________________________
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*______________________ *Phone:* ______________
*Emergency contact:*______________________ *Phone:* ______________

Birth date: ___/___/_____ **Age**:____
Sex: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐Unk
Preferred language: ____________
Country of Residence: ____________

Current Gender Identity
- ☐ Male
- ☐ Female
- ☐ Trans Male / transman
- ☐ Trans Female / transfemale
- ☐ Genderqueer or non-binary
- ☐ Identity 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) and number of sex partners (check all that apply)

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

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Other
Reporter Name: ______________________ Reporter Phone: ______________________
Primary HCP Name: ______________________ Primary HCP Phone: ______________________

CLINICAL

Onset date (mm/dd/yyyy): **Diagnosis date** (mm/dd/yyyy): **Recovery date** (mm/dd/yyyy):

Clinical Findings

Y N U
- ☐ ☐ ☐ Fever (Highest measured temperature:_______ ºF)
- ☐ ☐ ☐ Rash (approximate # lesions:________)
  - Type of rash: ☐Macular ☐Papular ☐Scabbing ☐Vesicular ☐Pustular ☐Drying ☐Pruritic ☐Umbilicated ☐Hemorrhagic ☐Unknown
  - Rash location(s): ____________________
  - Rash distribution: ____________________
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Swollen lymph nodes (neck, armpits, groin)
- ☐ ☐ ☐ Rectal pain/bleeding
- ☐ ☐ ☐ Muscle aches
- ☐ ☐ ☐ Back pain
- ☐ ☐ ☐ Abdominal pain
- ☐ ☐ ☐ Fatigue / Exhaustion
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Cough/Runny nose
- ☐ ☐ ☐ Sore Throat
- ☐ ☐ ☐ Eye/Ocular Involvement ☐Other ____________

Most recent documented weight:______ ☐kg ☐lb

Hospitalization

Y N U
- ☐ ☐ ☐ Patient hospitalized for this illness

If yes, hospital name: ______________________________
Admit date: : __/__/____ Discharge date:__/__/____
MRN: ______________________________
Date first sought medical care (inpatient or outpatient):__/__/____
Location(s) of Health Care Visits:
Facility/Office Name/Address:______________________________
Date of Visit: __/__/____ MRN:______________________

Death

Y N U
- ☐ ☐ ☐ Did the patient die? If yes, date of death:__/__/____
- ☐ ☐ ☐ Was death caused by this illness?

Clinical Risk Factors

Y N U
☐ ☐ ☐ Pregnant (if female) (due date:___________________)
☐ ☐ ☐ Underlying medical condition (list:_____________________)
☐ ☐ ☐ History of varicella disease
☐ ☐ ☐ Recent blood/organ donation or transfusion/implantation
Allergies to medication or other relevant medical history (including prior Mpox):____

Complications

Y N U
☐ ☐ ☐ Pneumonia
☐ ☐ ☐ Corneal ulcer or keratitis
☐ ☐ ☐ Encephalitis/meningitis
☐ ☐ ☐ Bacterial sepsis

VACCINATION HISTORY

Y N U
☐ ☐ ☐ Ever received smallpox or Mpox vaccine?
If yes, date(s): #1:__ /__ /____ #2:__ /__ /____
☐ ☐ ☐ Ever received varicella vaccine?
If yes, date(s): #1:__ /__ /____ #2:__ /__ /____
☐ ☐ ☐ Ever received measles, mumps, and rubella (MMR) vaccine?
If yes, date(s): #1:__ /__ /____ #2:__ /__ /____
#3: __ /__ /____

Treatment

Y N U
☐ ☐ ☐ Is patient on PrEP?
☐ ☐ ☐ Is patient receiving antiviral medication for Mpox?

LABORATORY

Y N U
☐ ☐ ☐ Clinical specimen positive by PCR for Mpox virus
☐ ☐ ☐ Clinical specimen positive by culture for Mpox virus
☐ ☐ ☐ Demonstration of Mpox viral antigens in a clinical specimen by immunohistochemical testing
☐ ☐ ☐ Observation of Mpox virus in a clinical specimen via electron microscopy

EPIDEMIOLOGIC EXPOSURES (based on the above exposure period)

Individual interviewed as patient proxy, if applicable:
Name: Relationship to patient: Contact information:

Y N U
☐ ☐ ☐ History of travel during exposure period (if yes, complete travel history below):
☐ ☐ ☐ If patient was on a flight, did the patient wear a mask? ☐ Cloth mask/gaiter ☐ Surgical Mask ☐ N95 or equivalent
If YES, was patient unmasked at any point while on the flight: ☐ Yes ☐ No
If YES, was patient unmasked for ≥ 3 hours while on the flight? ☐ Yes ☐ No ☐ Unsure

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for Travel	Traveled Alone?

Please document all accompanying travelers in the Mpox Contact Listing Form

Y N U
☐ ☐ ☐ Exposures to any of the following animals:
☐Prairie dog ☐Gambian rat ☐Rabbit ☐Wallaby ☐Rope squirrel ☐African tree squirrel ☐Other:______________
Where was animal obtained: ____
Earliest date of exposure:__ /__ /____ **Latest** date of exposure:__ /__ /____
Priority Level: ____________________________

Animal Contact: 1 = (highest priority) Direct: Bite, scratch, petting/handling, other direct physical contact; 2 = close contact: contact within 6 feet of the animal case with respiratory symptoms and manipulated; 3 = other > 6 feet of the animal case (e.g. not in the same room but in the same hospital or facility)
Human Contact: 1 = (highest priority) Case household/intimate contacts: all family members, housemates, intimate contacts, persons sharing a bed, others spending ≥ 3 hours in the household; 2 = Non-household close contacts: direct exposure to the human case for ≥ 3 hours and within 6 feet; 3 = Other: contact with human case for < 3 hours and < 6 feet; or any length of time exposure and ≥ 6 feet

Exposure setting (e.g., home, school, etc):____
Status of animal at time of exposure: ☐Alive (well) ☐Alive (ill) ☐Dead ☐Unknown
If animal was ill, date of animal's illness onset:__ /__ /____
Is animal available for testing? ☐Yes ☐No ☐Unknown

☐ ☐ ☐ Exposure to symptomatic human (specify relationship:__________________)
Earliest date of exposure:__ /__ /____ **Latest** date of exposure:__ /__ /____
Type of exposure: ☐ Skin-to-skin contact ☐ Sexual/intimate contact ☐ ≤ distance of 6 feet for >3 hours
☐ Contact with respiratory secretions ☐ Group event/outing ☐School
☐Other:____
Exposure setting (e.g., home, school, etc):____
☐ ☐ ☐ Group sex; festivals
☐ ☐ ☐ Organ transplant recipient (Date:___/__/_____)

Where did exposure most likely occur? **County:**________________**State:**__________**Country:** _________________

PUBLIC HEALTH ISSUES	PUBLIC HEALTH ACTIONS
Y N U	**Y N U**
☐ ☐ ☐ Case donated blood products, organs or tissue in the 30 days prior to symptom onset Date:__ /__ /____ Agency/location:____________________ Type of donation:____________________	☐ ☐ ☐ Notified blood or tissue bank
☐ ☐ ☐ Illegal pet trade suspected	☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
☐ ☐ ☐ Case knows someone who had shared exposure and is currently having similar symptoms	☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐ ☐ ☐ Epi link to another confirmed case of same condition	☐ ☐ ☐ Follow up of laboratory personnel exposed to specimen
☐ ☐ ☐ Epi link to a documented exposure	☐ ☐ ☐ Patient is lost to follow up
☐ ☐ ☐ Case is part of an outbreak	☐ ☐ ☐ Other:
☐ ☐ ☐ Exchange of money or drugs for sex	

NOTES

RUHS – Public Health
HIV/STD Branch

4065 County Circle Drive, Suite 308
Riverside, CA 92503
Phone: (951) 358-5307 | Fax: (951) 358-6007

Mpox Resources:

- CDC: Mpox Case Definitions - https://www.cdc.gov/poxvirus/mpox/clinicians/case-definition.html#print
- Cal/OSHA: Protecting Workers from Mpox For Employers and Workers Covered by the Aerosol Transmissible Diseases Standard - https://www.dir.ca.gov/dosh/documents/mpox-guidance.pdf
- CDPH: Mpox - http://go.cdph.ca.gov/mpox
- RUHS: Mpox for Providers - https://www.ruhealth.org/mpox-providers