NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF COMMUNICABLE DISEAES CONTROL

CONFIDENTIAL CASE REPORT

Last Name: _____**First Name**: _____**Phone Number**: (____) _____-_____

Address: **Street Number:** _____ **Street**: _____

Locality: _____ **Zip Code**: _____-_____

Date of Birth: _____ /_____/_____ **Age:** _____ **Census:**_____

Occupation/Setting

1 ☐ Food Service
2 ☐ Day Care
3 ☐ Health Care
4 ☐ Student/School
5 ☐ Inmate
6 ☐ Other Occupation _____
9 ☐ Unknown

Race

Choose all that apply.

☐ White
☐ Black
☐ Amer. Ind./Alaskan
☐ Asian
☐ Native Hawaiian or/ Other Pacific Islander
☐ Other
☐ Unknown

Ethnicity

1 ☐ Hispanic
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

Sex

1 ☐ Male
2 ☐ Female
9 ☐ Unknown

Pregnant

1 ☐ Yes
2 ☐ No
9 ☐ Unknown

Marital Status

1 ☐ Married
2 ☐ Single
9 ☐ Unknown

Hospitalized

1 ☐ Yes
2 ☐ No

Admission Date ____/____/_____ (MM/DD/YYYY)

Name of Hospital

Chart #

Disease: _____

Symptoms: _____

Dates: First Symptom: ____/____/_____ **Diagnosis**: ____/____/_____

Comments (Agent, laboratory data, treatment, etc):

Name of Lab: _____

Reporting Individual: _____ **Phone Number**: (___) ___-_____

Date of Report: ____/____/_____

DOH 389 (7/03)