

# Mumps

West Virginia Electronic Disease Surveillance System  
 Division of Surveillance and Disease Control  
 Infectious Disease Epidemiology Program  
 Phone - 304-558-5358 or 800-423-1271  
 Fax: 304-558-8736

Investigation Information			
* indicates required fields			
<b>Investigation Status*</b>			
<input type="checkbox"/> <i>Closed</i> <input type="checkbox"/> <i>Open</i> <input type="checkbox"/> <i>Regional Review</i> <input type="checkbox"/> <i>State Review</i> <input type="checkbox"/> <i>Superseded</i> <input type="checkbox"/> <i>Unassigned</i>			
<b>Case Status*</b>			
<input type="checkbox"/> <i>Confirmed</i> <input type="checkbox"/> <i>Probable</i> <input type="checkbox"/> <i>Suspect</i> <input type="checkbox"/> <i>Not a Case</i> <input type="checkbox"/> <i>Unknown</i>			
Patient Information			
* indicates required fields			
<b>Last Name*</b>	<b>First Name*</b>	<b>Middle Initial</b>	
<b>Street Address</b>			
<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>
<b>Is this residence a:</b>			
<input type="checkbox"/> <i>Correctional Facility (Specify facility)</i> _____			
<input type="checkbox"/> <i>Long Term Care Facility (Specify facility)</i> _____			
<input type="checkbox"/> <i>Shelter or Group Home (Specify facility)</i> _____			
<b>Home Phone</b> ###-###-####	<b>Ext.</b>	<b>Other Phone</b> ###-###-####	<b>Ext.</b>
<b>Patient Status*</b>		<b>Patient Status Date*</b>	
<input type="checkbox"/> <i>Inpatient</i> <input type="checkbox"/> <i>Outpatient</i> <input type="checkbox"/> <i>Died</i> <input type="checkbox"/> <i>Unknown</i>		mm/dd/yyyy <span style="float: right;">to</span>	
Parent / Guardian Information			
<b>Last Name</b>	<b>First Name</b>	<b>Middle Initial</b>	<b>Relationship to Patient</b>
<input type="checkbox"/> <i>Check if address is same as above; otherwise complete guardian contact information below</i>			
<b>Guardian Street Address</b>			
<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone</b> ###-###-####	<b>Ext.</b>	<b>Other Phone</b> ###-###-####	<b>Ext.</b>

**Patient Demographic Information**

\* indicates required fields

**Sex**  
 Male  Female  Transsexual  Unknown  Failure to report sex/missing sex  Other \_\_\_\_\_

<b>Date of Birth*</b> mm/dd/yyyy	<b>Age</b>	<b>Age Units</b> <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
----------------------------------	------------	---

**Ethnicity**  
 Hispanic or Latino  Not Hispanic or Latino  Unknown  Failure to report ethnicity/missing ethnicity

**Race** (Check all that apply)  
 American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  
 White  Unknown  Failure to report race/missing race  Some other race

**Outcome and Clinical Information**

<b>Date of onset of symptoms</b> mm/dd/yyyy	<b>If not symptomatic, Date of diagnosis</b> mm/dd/yyyy
--	---

<b>Was patient hospitalized for this disease?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Name of Hospital</b>	<b>Date of Admission</b> mm/dd/yyyy	<b>No. of days hospitalized:</b> _____ days
--	-------------------------	--	--

<b>Hospital Address</b> (Street address, city, county and state)	<b>Hospital phone no.</b> ###-###-####
--	--

<b>Was patient admitted to the ICU?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Was patient hospitalized for a mump-related complication?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

<b>Primary reason for hospitalization</b>	<b>Admission diagnosis(es)</b> (Chart and/or ICD code)	<b>Discharge diagnosis(es)</b> (Chart and/or ICD code)
---	--	--

<b>Outcome of hospitalization</b> <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> In hospital at time of interview <input type="checkbox"/> Unknown	<b>If Patient Died from Mumps</b> (verification with the physician is recommended) <b>Date of Death</b> mm/dd/yyyy
--	---

**Death Certificate Diagnosis**

**Postmortem Examination Results**

**Clinical Signs and Symptoms**

<b>Parotid Swelling (Parotitis)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Date of Onset of Parotitis</b> mm/dd/yyyy	<b>Is Parotid Swelling</b> <input type="checkbox"/> Unilateral or <input type="checkbox"/> Bilateral	<b>Duration of Parotid Swelling</b> _____ days
--	---	---	---

**Sublingual or Submaxillary Swelling**  
 Yes  No  Unknown

<b>Headache</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Fever</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>If yes, maximum recorded temperature (T max) and Date</b> mm/dd/yyyy	
<b>Malaise</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Myalgias</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Arthritis/Arthralgias</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Other Signs and Symptoms</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Abdominal/Pelvic Pain</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
		<b>If yes, specify:</b>			
<b>Treatment</b>					
<b>List Medications Given</b> (e.g., antiviral drugs, Varicella Zoster Immunoglobulin (VZIG), aspirin, non-steroidal anti-inflammatory drugs)			<b>Duration of Treatment</b>  days		
<b>Mumps-associated Complications</b>					
<b>Aseptic Meningitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Encephalitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Orchitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Mastitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Oophoritis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Myocarditis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Deafness</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Pancreatitis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Nephritis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		<b>If yes, was the deafness</b> <input type="checkbox"/> Transient(Resolved) or <input type="checkbox"/> Permanent <input type="checkbox"/> Unknown		<b>Arthropathy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>If yes, is it</b> <input type="checkbox"/> Polyarticular migratory <input type="checkbox"/> monoarticular		<b>Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>If Yes, specify</b>	
<b>Underlying Medical Conditions</b>					
<b>List Any Underlying Chronic Medical Conditions</b>					
<b>List Any Concurrent Acute Medical Conditions</b>					

<b>Mumps Diagnostics (Laboratory Testing)</b>	
<b>Was Laboratory Testing for Mumps Done?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Mumps Serologies</b>	
<input type="checkbox"/> IgM <input type="checkbox"/> Acute IgG <input type="checkbox"/> Convalescent IgG	
<b>Acute Specimen Collection Date</b> mm/dd/yyyy	<b>Convalescent Specimen Collection Date</b> mm/dd/yyyy
<b>Results of IgM</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	
<b>Results of IgG</b> <input type="checkbox"/> Significant Rise in IgG <input type="checkbox"/> No Significant Rise in IgG <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	

**Mumps Viral Isolation**

<b>Collection Date</b> mm/dd/yyyy	<b>Specimen type</b> (check all that apply) <input type="checkbox"/> Buccal swab <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Urine
-----------------------------------	--

<b>Result</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown
---

**Other Laboratory/Studies**

<b>Lumbar Puncture</b> <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
--

<b>Results</b>
----------------

<b>Urine Analysis</b> <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
---

<b>Results</b>
----------------

<b>Creatinine</b> <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
---

<b>Results</b>
----------------

<b>EKG</b> <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
--

<b>Results</b>
----------------

**Reporting Source**

<b>Last Name</b>	<b>First Name</b>
------------------	-------------------

<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Fax</b> ###-###-####
---------------------------	-------------	-------------------------

<b>Facility</b>
-----------------

<b>Address</b>
----------------

<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>
-------------	---------------	--------------	------------

<b>E-mail</b>
---------------

<b>Earliest date reported</b> (the first date reported to a health department, either local, regional, or state) (mm/dd/yyyy)
--

**Provider with Further Patient Information**

<b>Last Name</b>	<b>First Name</b>
------------------	-------------------

<b>Phone</b> ###-###-####	<b>Ext.</b>	<b>Fax</b> ###-###-####
---------------------------	-------------	-------------------------

<b>Address</b>			
<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>

### Public Health Investigation

<b>Name of Person Interviewed</b>	<b>Relationship to Patient</b>	<b>Date of Interview</b> mm/dd/yyyy
-----------------------------------	--------------------------------	-------------------------------------

<b>Investigator</b>	<b>Health Department</b>	<b>Phone</b> ###-###-####	<b>Ext.</b>
---------------------	--------------------------	---------------------------	-------------

<b>Does Patient Attend/Work at Daycare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If yes, Name of the Daycare and Contact Name</b>  	<b>Daycare Address and Phone No.</b> (street, city, county, state, zip)
--	---	---

<b>Is Patient a Student?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If Yes, Name of the School and Contact Name</b> (School Nurse)	<b>School Address and Phone No.</b> (street, city, county, state, zip)
---	--	--

<b>Does Patient Attend College?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If Yes, Name of the College or Post-High School Educational Institution and Contact Name</b>	<b>College Address and Phone No.</b> (street, city, county, state, zip)
--	---	---

<b>Does Patient Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If yes, Name of the Workplace and Contact Name</b>	<b>Work Address and Phone No.</b> (street, city, county, state, zip)
--	---	--

<b>Is Patient a Healthcare Worker?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Is Patient Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

<b>Country of birth</b>	<b>Length of time in U. S. if Born Outside of US?</b>  months      years
-------------------------	--

<b>Investigation ID</b>	<b>Part of an Outbreak?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Outbreak Name</b>	<b>Lost to follow-up?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------	--	----------------------	---

**Imported** (where did the patient occur mumps)?

*Indigenous* (In-state = any case which cannot be proven to be imported)

*International* (Out of USA = international importation from another country = onset of symptoms is within 18 days of entering the US)

*Out of state* (Importation from another state = documentation that the person either had face-to-face contact with a case of mumps outside the state, or was out of state for the entire period when he or she might have become infected [7-18 days before onset of symptoms])

*Unknown*

### Vaccine Information

<b>Received mumps containing vaccine?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Number of Doses of mumps containing vaccine received ON or AFTER 1st birthday</b>
--	--

**If Not Vaccinated, What Was the Reason?**

<input type="checkbox"/> <i>Religious Exemption</i>	<input type="checkbox"/> <i>Medical Contraindication</i>	<input type="checkbox"/> <i>Philosophical Exemption</i>
<input type="checkbox"/> <i>Lab Evidence of Previous Disease</i>	<input type="checkbox"/> <i>MD Diagnosis of Previous Disease</i>	<input type="checkbox"/> <i>Under Age For Vaccination</i>
<input type="checkbox"/> <i>Parental Refusal</i>	<input type="checkbox"/> <i>Unknown</i>	



