Appendix 2: Nigeria Monkeypox Case Investigation Form

Epid number**:**

Date of investigation: ____/___/___

Case reported by *name* _____ *title*_____ *phone no.*_____

Section 1: Patient Identity

1. Last Name_____ First Name _____
2. For children, father's name _____
3. Date of birth ___/___/___
4. Age in days (neonate) _____Age in months (Infant) _____Age in years (others) _____
5. Gender □ M □ F
6. Village/settlement/street of residence during the last 3 weeks_____
7. State _____ LGA _____ WARD_____
8. Nationality _____ Ethnicity / Tribe_____
9. Occupation of the patient_____

Section 2: Patient status

10. Status of the patient: □ Alive □ Dead
11. If dead, date of death ___/___/___ Place of death: _____
12. Place of the funeral, name village: _____ LGA_____ State _____
13. Is a Smallpox vaccination scar present? □ Yes □ No

Section 3 : Clinical History / Presentation

14. Date of onset of symptoms**:** __/___/___
15. Name of the village / LGA/State where the patient got ill_____/_____/_____
    *Country*_____
16. a. Did the patient travel anytime in the three weeks before becoming ill?: □ Yes □ No
    b. If yes, indicate the places __ (1) _____ (2) _____ (3) _____
    Others: _____
17. a. Did the patient travel during illness?: □ Yes □ No
    b. If Yes, indicate the places __ (1) _____ (2)_____(3)_____
    Others: _____
18. Does the patient have a cutaneous eruption/rash? □Yes □ No
19. If yes, date of onset for the rash: ___/___/___
20. Did the patient have fever? □ Yes □ No . If yes, date of onset for the fever: ___/___/___
21. If there is active disease,
    a. Are the lesions in the same state of development on the body? □ Yes □ No
    b. Are all of the lesions the same size? □Yes □ No
    c. Are the lesions deep and profound? □Yes □ No
22. Localisation of the lesions □Face □Legs □Soles of the fee □ Palms of the hands
    □ Thorax □ Arms □ Genitals □All over the body
    List other areas : _____
23. Did the patient develop ulcers ? □Yes □ No

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24. Does or did the patient have any of the following symptoms (check all that apply)

Vomiting/nausea	□ Yes	□ No	Headache	□ Yes	□ No
Cough	□ Yes	□ No	Lesions that itch	□ Yes	□ No
Lymphadenopathy, inguinal	□ Yes	□ No	Muscle pain (myalgia)	□ Yes	□ No
Lymphadenopathy, axillary	□ Yes	□ No	Fatigue	□ Yes	□ No
Lymphadenopathy, cervical	□ Yes	□ No	Conjunctivitis	□ Yes	□ No
Chills or sweats	□ Yes	□ No	Sensitivity to light	□ Yes	□ No
Sore throat when swallowing	□ Yes	□ No	Is the patient bedridden?	□ Yes	□ No
Oral ulcers	□ Yes	□ No			

25. If female, Pregnancy status: □ Pregnant □ Not pregnant
26. HIV status: □ Negative □ Positive □ Unknown
27. Any other known medical condition (Please state)

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Section 4 : Exposure

28. During the three weeks preceding the onset of symptoms, did the patient have contact with one or more persons who had similar symptoms? □Yes □ No

If yes, respond to the following questions concerning these additional ill people (indicate all of the ill people). There is additional space for multiple contacts at the end of this form.

29. Last name _____ First name _____
30. Relationship with the patient _____
31. First date of contact with the ill person ___/___/___
32. Did the patient touch a domestic or wild animal during the three weeks preceding symptom onset?
□ Yes □ No
33. If Yes, what kind of animal_____
34. Date of contact ___/___/___
35. Type of contact (*check all that apply)*

□ Rodents alive in the house
□ Dead animal found in the forest
□ Alive animal living in the forest
□ Animal bought for meat
Others:_____

Section 5: Laboratory

36. Was a specimen collected? □ Yes □ No 35. If Yes, date ___/___/___
37. Type: □ Crust □ Swab □ Blood

Collect at least two types of specimens from each patient. For each specimen: place a label on this form and a label on the specimen tube. Ensure that the two labels have the same name/number of the specimen.

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Section 6: Update on the Hospital information

38. Was the patient sent to a hospital? ☐ Yes ☐ No

39. Was the patient admitted in the isolation ward? ☐ Yes ☐ No

40. If Yes, name of hospital_____ Hospitalization date ___/___/__

41. Date of discharge___/___/___OR Date of death___/___/__

Section7: Additional contacts of the patient (Question 28)

Full Name	Location/Address	Date of contact	Sex	Relationship	Type of contact e.g. touch, breastfeeding, sexual

Appendix 3: Contact Listing Form

s/no	Surname	Other names	Sex (M/F)	Age (yrs)	Relation to case	Date of last contact with case	Type of contact (1,2 or 3)	Head of household	Address	Town	LGA	Phone number	Occupation