



ID: ...../200..../ICT

## QUESTIONNAIRE FOR SUSPECTED CASES OF HUMAN INFLUENZA

National Influenza Lab Based Surveillance Project, Public Health Laboratories Division,  
National Institute of Health (NIH), Islamabad.

**This form to be sent with specimen to Influenza Lab, Virology Department,  
Public Health Laboratories Division, National Institute of Health (NIH), Islamabad.**

Date this form filled: \_\_\_\_\_

*Note: Specimens to be collected from the suspected cases / patients with recent onset  
(within 3-7 days) meeting criteria as follows:*

- Sudden onset of fever  $>38^{\circ}\text{C}$  ( $>100.4^{\circ}\text{F}$ ). Yes No Unknown
- **AND** Cough and/or Sore throat and/or Shortness of Breath. Yes No Unknown
- **AND / OR** any one of the following: (for suspected Avian Influenza)

Any **past** (7 days prior to appearance of first symptom) **history** of; Please check one

1. Contact with a person who has high fever / SOB / cough / sore throat? Yes No Unknown
2. Contact with live or dead birds or poultry (eating raw or undercooked poultry / touching holding / preparing food / culling / burying) Yes No Unknown
3. Lived or visited a place where poultry deaths have occurred? Yes No Unknown
4. Animal related worker, health care worker or laboratory worker involved in sample processing of suspected cases? Yes No Unknown

5. Is this suspect a high risk case? Yes No Unknown
6. Is this suspect part of an outbreak investigation? Yes No Unknown

7. Source of Suspected Case / Patient:  
 Community. Location.....(If community go to Q.No. 12)  
 Hospital.  
FGSH PIMS CDA RGH FFH Other

8.  Outpatient (Dept. name: \_\_\_\_\_)  Inpatient (Ward name: \_\_\_\_\_)

9. Case / Patient Number: \_\_\_\_\_ 10. Date of Admission: \_\_\_\_\_

11. Reported By: \_\_\_\_\_

12. Suspected Case / Patient's Name: \_\_\_\_\_

13. Father's / Husband's Name: \_\_\_\_\_

14. Date of Birth: \_\_\_\_\_ 15. Age: \_\_\_\_\_ yrs.

16. Gender: Male Female

17. Address: .....

.....

City..... District..... Province.....

Phone No: \_\_\_\_\_

18. Address where onset occurred:	<input type="checkbox"/> As above	<input type="checkbox"/> Other Address.....
19. Occupation:		
20. Socioeconomic Status / Income:		
21. Influenza vaccination history within last year:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
22. If taking any antivirals / antibiotics:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, what

<b>23. Clinical Manifestations: (from onset until now)</b>		
a. Date of onset of symptoms:		
b. Fever >38 °C (>100.4 °F)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
Date of onset of fever:	If yes, Temp..... °F	
c. Cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
d. Sore throat:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
e. Shortness of breath:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
f. Diarrhoea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
g. If less than 5 years:		
• Unable to drink or breastfeed.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
• Lethargic or unconscious.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
• Vomiting.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
• Convulsions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
h. Others:		

<b>24. Pre-Existing Medical Conditions:</b>			
a. Allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown, If yes what
	<input type="checkbox"/> Food	<input type="checkbox"/> Dust	<input type="checkbox"/> Pollen <input type="checkbox"/> Drug <input type="checkbox"/> Other.....
b. Respiratory disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown If yes, what.....
c. Liver disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown If yes, what.....
d. Metabolic disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown If yes, what.....
e. Heart disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown If yes, what.....
f. Smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown If yes, No. of pack years.....

25. Samples collected:	<input type="checkbox"/> Throat swab	<input type="checkbox"/> Nasopharyngeal swab	<input type="checkbox"/> Serum
26. Date of sample collection:			

<b>Sample collected by:</b> (Signature and full name)	<b>Physician filling this form:</b> (Signature and full name)	<b>Coordinator of surveillance unit:</b> (Signature and full name)
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