# LYME DISEASE CASE REPORT FORM

Montgomery County Health Department

Patient's last name_____ First name_____ Tele. No.(_____)_____

Address_____ City_____

State_____ County_____ Zip_____ CT#_____

Age (yrs.)_____ Sex___M Race___Amer. Indian/Eskimo Ethnicity___Hispanic

___F ___Asian/Pacific Isl. ___Non Hisp.

Date of Birth_____ ___Unspec. ___Black ___Unknown

___White

___Unknown

*****Has this patient been diagnosed with Lyme disease by a physician?** - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

**SIGNS AND SYMPTOMS OF CURRENT EPISODE (PLEASE MARK EACH QUESTION):**

ERYTHEMA MIGRANS:

Erythema migrans (physician diagnosed **EM at least 5 cm** in diameter)? - - - - - - - - - - - - - - - - [Y] [N] [?]

RHEUMATOLOGIC:

Arthritis **characterized by brief attacks of swelling in one or a few joints**? - - - - - - - - - - - - - - [Y] [N] [?]

NEUROLOGIC:

Bell's palsy or other cranial neuritis? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

Radiculoneuropathy? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

Lymphocytic meningitis? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

Encephalitis/Encephalomyelitis? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

CSF tested for antibodies to B. ***burgdorferi***? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

Antibody to B. *burgdorferi* higher in CSF than serum? - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

CARDIOLOGIC:

2nd or 3rd degree atrioventricular block? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - [Y] [N] [?]

Other clinical signs and symptoms:_____

Date onset first signs & symptoms __/__/__ (mo dy yr) Date of Dx__/__/__ (mo dy yr) Date of test __/__/__ (mo dy yr) Date reported to Health Dept. __/__/__ (mo dy yr)

**OTHER INFORMATION ON PATIENT**

Was patient hospitalized for current episode? [Y] [N] [UNK] Date of Admission _____(MM/DD/YYYY)

Antibiotic(s) used for this episode? [Y] [N] Name:_____ Duration of Rx_____(days)

Name: _____ Duration of Rx_____(days)

Combined Duration of Rx _____(days)

Was patient pregnant at time of illness? [Y] [N] [UNK]

Did patient travel outside Montgomery County within the last 30 days before onset? [Y] [N] [UNK] If yes, where? _____

Did patient find a tick on his/her body? [Y] [N] [UNK] Does patient live close to a wooded/brushy area? [Y] [N] [UNK]

What **activities** may have exposed patient to tick bite (circle one)?

- Occupational: (landscaping), ( park warden), (utility work), other _____
- Recreational: (gardening), (camping), (hiking), (outdoor sports), (cross country jogging),other _____

**LABORATORY RESULTS**

| | Positive | Negative | Equivocal | Not Done | Unknown |
|---|---|---|---|---|---|
| Serologic test results: | ☐ | ☐ | ☐ | ☐ | ☐ |
| Culture results: | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other (specify) | ☐ | ☐ | ☐ | ☐ | ☐ |

Physician's Name_____ Person Completing Form_____

Address_____ Address_____

Telephone Number (___) _____ Telephone Number (____)_____