CONFIDENTIAL MORBIDITY REPORT

CITY OF PASADENA
PUBLIC HEALTH DEPARTMENT

Note: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements are available on the List of Reportable Diseases and Conditions.

DISEASE BEING REPORTED →

Patient Last Name	First Name	MI	Birthdate (mm/dd/yyyy)	Age

Address (Street and number)	Apt./Unit No.

City/Town	State	Zip Code

Home Telephone Number	Cell Telephone Number	Work Telephone Number
( )	( )	( )

Patient's Occupation/Setting (check all that apply)
☐ Food Service ☐ Day Care ☐ Correctional Facility
☐ Health Care ☐ School ☐ Other:_____

Gender
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Other:_____

Pregnant?
☐ Yes _____ Est. Delivery Date
☐ No ☐ Unknown

Date of Onset (mm/dd/yyyy)	Date Diagnosed (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)

Race (check all that apply)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Ethnicity (check one)
☐ African-American/Black
☐ Asian/Pacific Islander (check one)
☐ Asian-Indian ☐ Filipino ☐ Cambodian
☐ Chinese ☐ Japanese ☐ Guamanian
☐ Hawaiian ☐ Korean ☐ Laotian
☐ Samoan ☐ Vietnamese ☐ Other:_____
☐ Native American/Alaskan Native
☐ White
☐ Other:_____

Reporting Health Care Provider

Reporting Health Care Facility

Type of Diagnostic Specimen
☐ Blood ☐ CSF ☐ Clinical
☐ Stool ☐ Urine ☐ No test
☐ Other:_____

Address (Street and number)	Suite/Unit No.

City/Town	State	Zip Code

Telephone Number	Fax Number	Date Submitted (mm/dd/yyyy)

Submitted by

REPORT TO:
PASADENA PUBLIC HEALTH
FAX: (626) 744-6115
MAIL: 1845 N. Fair Oaks
Pasadena, CA 91103
PHONE: (626) 744-6043

SEXUALLY TRANSMITTED DISEASES (STD)

Syphilis
☐ Syphilis
☐ Neurosyphilis

Syphilis Test Results
RPR Titer:_____
VDRL Titer:_____

Gonorrhea
☐ Urethral/Cervical
☐ PID
☐ Other:_____

Chlamydia
☐ Urethral/Cervical
☐ PID
☐ Other:_____
☐ PID (Unknown etiology)
☐ Chancroid
☐ Non-Gonococcal Urethritis

Gender of Sex Partners (check all that apply)
☐ Male
☐ Female
☐ M to F Transgender
☐ F to M Transgender
☐ Other:_____

STD Treatment Information
☐ Treated (Drugs, Dosage, Route):
_____
_____

Treatment Began (*mm/dd/yyyy*):
____/____/____

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to:_____

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Jaundiced? ☐ Yes ☐ No

Suspected Exposure Type(s)
☐ Blood transfusion
☐ Medical or dental procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other:_____

ALT (SGPT)
Result: _____
Upper Limit: _____

AST (SGOT)
Result: _____
Upper Limit: _____

Bilirubin Result: _____

	Pos	Neg
Hepatitis A		
anti-HAV IgM	☐	☐
Hepatitis B		
HBsAg	☐	☐
anti-HBc total	☐	☐
anti-HBc IgM	☐	☐
anti-HBs	☐	☐
HBeAg	☐	☐
anti-HBe	☐	☐
HBV DNA: _____		

	Pos	Neg
Hepatitis C		
anti-HCV	☐	☐
RIBA	☐	☐
HCV RNA (e.g., PCR)	☐	☐
Hepatitis D		
anti-HDV	☐	☐
Hepatitis E		
anti-HEV	☐	☐

TUBERCULOSIS (TB)

Status
☐ **Active Disease**
☐ Confirmed
☐ Suspected
☐ **Infected, No Disease**
☐ Converter
☐ Reactor

Site(s)
☐ Pulmonary
☐ Extra-Pulmonary
☐ Both

Mantoux TB Skin Test
Date performed (*mm/dd/yyyy*):
____/____/____
Results: _____mm
☐ Pending ☐ Not Done

Chest X-Ray
Date performed (*mm/dd/yyyy*):
____/____/____
☐ Normal ☐ Pending ☐ Not done
☐ Cavitary ☐ Abnormal/Noncavitary

Bacteriology
Date specimen collected (*mm/dd/yyyy*):
____/____/____
Source: _____
Smear: ☐ Pos ☐ Neg ☐ Pending ☐ Not done
Culture: ☐ Pos ☐ Neg ☐ Pending ☐ Not done
Other test(s): _____
_____

TB TREATMENT INFORMATION
☐ **Current Treatment**
☐ INH ☐ RIF ☐ PZA
☐ EMB ☐ Other: _____
Date treatment initiated (*mm/dd/yyyy*): ____/____/____

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Refused treatment
☐ Referred to: _____
_____

REMARKS: