State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

Local ID Number ___________________________

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)
☐ Preliminary ☐ Final

BOTULISM
CASE REPORT

Check one: ☐ Foodborne ☐ Wound ☐ Other (specify):_______________

THIS FORM SHOULD NOT BE USED FOR INFANT BOTULISM

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ Years ☐ Months ☐ Days

Address Number & Street - Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*
Work / School Location	*Work / School Contact*

Gender
☐ Male ☐ Female ☐ Other: ______________________________

Pregnant? ☐ Yes ☐ No ☐ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*
Medical Record Number	*Patient's Parent / Guardian Name*
Occupation Setting (see list on page 10)	*Other (Describe / Specify)*
Occupation (see list on page 10)	*Other (Describe / Specify)*

Primary Language
☐ English
☐ Spanish
☐ Other:_____________________

Ethnicity (check one)
☐ Hispanic / Latino
☐ Non-Hispanic / Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 10)
☐ African-American / Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Japanese
- ☐ Cambodian ☐ Korean
- ☐ Chinese ☐ Laotian
- ☐ Filipino ☐ Thai
- ☐ Hmong ☐ Vietnamese
- ☐ Other:_____________________

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian
- ☐ Other:_____________________

☐ White
☐ Other:___________________
☐ Unk

*Comment: self-identity or self-reporting
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

CLINICAL INFORMATION

Physician 1	*Last Name*	*First Name*		
	Specialty ☐ Infectious diseases ☐ Neurologist ☐ Other (specify):____________________		*Telephone Number*	*Fax Number*
Physician 2	*Last Name*	*First Name*		
	Specialty ☐ Infectious diseases ☐ Neurologist ☐ Other (specify):____________________		*Telephone Number*	*Fax Number*

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unk	*Onset Date (mm/dd/yyyy)*	*Onset Time (hh:mm)*	*Specify AM/PM*
Date of First Neurologic Symptoms (mm/dd/yyyy)		*Date First Sought Medical Care (mm/dd/yyyy)*	

Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Nausea				Change in sound of voice			
Vomiting				Hoarseness			
Abdominal pain				Dry mouth			
Diarrhea				Dysphagia (trouble swallowing)			
Constipation				Shortness of breath / trouble breathing			
Diplopia (double vision) / blurred vision				Subjective weakness			
Dizziness				Fatigue			
Slurred speech				Paresthesia			
Thick tongue				*Other signs / symptoms (specify)*			

PHYSICAL EXAM FINDINGS

Observation	Yes	No	Unk	If Yes, Specify as Noted	
Alert and oriented					
Extraocular palsy				*Is it bilateral?* ☐ Yes ☐ No ☐ Unk	
Ptosis				*Is it bilateral?* ☐ Yes ☐ No ☐ Unk	
Pupil abnormality				*Abnormality* ☐ Dilated ☐ Constricted ☐ Non-reactive	*Is it bilateral?* ☐ Yes ☐ No ☐ Unk
Facial paralysis				*Is it bilateral?* ☐ Yes ☐ No ☐ Unk	
Palatal weakness				*Is it bilateral?* ☐ Yes ☐ No ☐ Unk	
Impaired gag reflex					
Sensory deficit(s)				*Specify*	
Muscle weakness and / or paralysis				*Progression of weakness / paralysis* ☐ Ascending, ending with cranial nerves ☐ Descending, beginning with cranial nerves ☐ Other (specify):____________________	*Is it bilateral?* ☐ Yes ☐ No ☐ Unk
Ataxia					
Abnormal deep tendon reflexes				*Describe*	
Other signs / symptoms (specify)					

First three letters of patient's last name: | | | |

MUSCLE STRENGTH EXAM

Proximal Upper Extremity	*Distal Upper Extremity*	Scale:
Right:____ / 5 Left:____ / 5	*Right:____ / 5 Left:____ / 5*	0 = no evidence of contractility 1 = slight contractility, no movement 2 = full range of motion, gravity eliminated
Proximal Lower Extremity *Right:____ / 5 Left:____ / 5*	*Distal Lower Extremity* *Right:____ / 5 Left:____ / 5*	3 = full range of motion with gravity 4 = full range of motion against gravity, some resistance 5 = full range of motion against gravity, full resistance 9 = unknown

CLINICAL TESTS

Type of Test	Yes	No	Unk	If Yes, Specify as Noted		
Lumbar puncture (CSF analysis)				*WBC count (highest)*	*RBC count*	*Opening pressure*
				Protein (highest)	*Glucose*	*Date (mm/dd/yyyy)*
EMG (If copy of EMG test report is available, please attach copy.)				*Result* ☐ Suggestive of / consistent with botulism ☐ Not consistent with botulism ☐ Unk		
				Was EMG done with rapid stimulation? ☐ Yes ☐ No ☐ Unk	*If Yes, what Hertz?*	*Date (mm/dd/yyyy)*
Edrophonium (Tensilon)				*Describe results*		*Date (mm/dd/yyyy)*
CT or MRI scan				*Describe results*		*Date (mm/dd/yyyy)*

PAST MEDICAL HISTORY

Prior botulism diagnosis? ☐ Yes ☐ No ☐ Unk	*If Yes, specify prior diagnosis date (mm/dd/yyyy)*
Prior neurological impairment? ☐ Yes ☐ No ☐ Unk	*If Yes, describe impairment*
Allergy to equine products? ☐ Yes ☐ No ☐ Unk	*If Yes, describe*
Immunocompromised? ☐ Yes ☐ No ☐ Unk	*If Yes, specify condition*
Other (specify)	

DID PATIENT USE ANY DRUGS THAT COULD CAUSE MUSCULAR PARALYSIS WITHIN 30 DAYS BEFORE ILLNESS ONSET?

Myobloc (toxin-type B)?	*Botox (toxin-type A)?*	*Aminoglycoside (gentamicin, tobramycin)?*	*Anticholinergic?*
☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk
Other (specify)			

First three letters of patient's last name: | | | |

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	Was patient hospitalized? ☐ Yes ☐ No ☐ Unk	If Yes, how many total hospital nights?
If there were any ER or hospital stays related to this illness, specify details below.		

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

TREATMENT / MANAGEMENT

Was antitoxin released / authorized? ☐ Yes ☐ No ☐ Unk	Date of Antitoxin Release (mm/dd/yyyy)		Time of Antitoxin Release (HH:MM AM/PM)
	Officer Releasing Antitoxin - Last Name, First Name		
	Name of Hospital / Pharmacy that Received Antitoxin		Pharmacy Phone Number
Received botulinum antitoxin? ☐ Yes ☐ No ☐ Unk	Number of Doses Used	Antitoxin Type - First Dose ☐ Cangene heptavalent ☐ Unk ☐ Other (specify):______________	Date Administered (mm/dd/yyyy)
		Antitoxin Type - Second Dose ☐ Cangene heptavalent ☐ Unk ☐ Other (specify):______________	Date Administered (mm/dd/yyyy)
Admitted to ICU? ☐ Yes ☐ No ☐ Unk	Admit Date (mm/dd/yyyy)		
Intubated and placed on ventilator? ☐ Yes ☐ No ☐ Unk	Intubation Date (mm/dd/yyyy)		

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unk	If Survived, Survived as of ________________________________(mm/dd/yyyy)	Date of Death (mm/dd/yyyy)

ADDITIONAL COMMENTS

First three letters of patient's last name: | | |

LABORATORY INFORMATION

CLINICAL SPECIMENS - DIRECT TOXIN TESTING

Specimen Type 1
☐ Gastric aspirate
☐ Serum (pre-toxin)
☐ Serum (post-toxin)
☐ Stool

Result
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unk

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

Specimen Type 2
☐ Gastric aspirate
☐ Serum (pre-toxin)
☐ Serum (post-toxin)
☐ Stool

Result
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unk

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

CLINICAL SPECIMENS - CULTURE TESTING

Specimen Type 1
☐ Gastric aspirate
☐ Stool
☐ Wound or abscess (specify site): ____________
☐ Other (specify): ____________

Result
☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unk
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

Specimen Type 2
☐ Gastric aspirate
☐ Stool
☐ Wound or abscess (specify site): ____________
☐ Other (specify): ____________

Result
☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unk
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

FOOD SPECIMENS

Type of Food Item 1 (specify)

Food Identification #	*Did the patient eat this item in the week before illness onset?*	*Did anyone else eat this item in the week before patient's illness onset?*
	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk

Direct Toxin Testing Results
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unk

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Culture Testing Results
☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unk
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy)	*Laboratory Name*	*Telephone Number*

(continued on page 6)

First three letters of patient's last name: | | | |

FOOD SPECIMENS (continued)

Type of Food Item 2 (specify)

Food Identification #

Did the patient eat this item in the week before illness onset? ☐ Yes ☐ No ☐ Unk

Did anyone else eat this item in the week before patient's illness onset? ☐ Yes ☐ No ☐ Unk

Direct Toxin Testing Results
☐ No botulinum toxin detected ☐ Other or unknown toxin detected ☐ Test cancelled
☐ Botulinum toxin detected ☐ Insufficient or unsatisfactory sample ☐ Unk

Type of Toxin Detected
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ Untypeable ☐ Unk

Culture Testing Results
☐ No *Clostridium* organism isolated ☐ *Clostridium butyricum* organism isolated ☐ Test cancelled
☐ *Clostridium botulinum* organism isolated ☐ Other clostridial species ☐ Unk
☐ *Clostridium baratii* organism isolated ☐ Insufficient or unsatisfactory sample

Type of Toxin Produced by Organism
☐ Type A ☐ Type B ☐ Type ABE ☐ Type C ☐ Type D ☐ Type E ☐ Type F ☐ Type G ☐ None ☐ Untypeable ☐ Unk

Collection Date (mm/dd/yyyy) | *Laboratory Name* | *Telephone Number*

ADDITIONAL INFORMATION

If post-antitoxin test was performed and was positive, describe circumstances.

Additional antitoxin given? ☐ Yes ☐ No ☐ Unk

EPIDEMIOLOGIC INFORMATION

EXPOSURES / RISK FACTORS - WOUND AND DRUG USE

Provide information regarding the patient's wound and drug use below.

Wound / Drug Use	Yes	No	Unk	If Yes, Specify as Noted
Wound or abscess				*Date of injury (mm/dd/yyyy)*; *Location(s)*; *Description*; *How wound occurred*; *Did / does wound appear infected?* ☐ Yes ☐ No ☐ Unk
Injects black tar heroin (chiba)				*Date last used (mm/dd/yyyy)*; *Injection method* ☐ Intravenous ☐ Subcutaneous (skin-pop) ☐ Unk ☐ Intramuscular ☐ Other:________________
Injects other drugs				*Drugs injected* ☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ Unk ☐ Other:_____________________; *Injection method* ☐ Intravenous ☐ Subcutaneous (skin-pop) ☐ Unk ☐ Intramuscular ☐ Other:________________
Sniffs / snorts drugs				*Drugs sniffed / snorted* ☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ Unk ☐ Other:_____________________
Other drug use				*Describe type of use and drugs*

First three letters of patient's last name: | | |

EXPOSURES / RISK FACTORS - POTENTIAL HIGH RISK PRODUCTS

ASK ABOUT HIGH RISK FOODS EVEN IF WOUND BOTULISM IS SUSPECTED
(SUCH AS HOME CANNED OR SUSPICIOUS COMMERCIAL OR RESTAURANT FOODS)

Provide information regarding potential high risk products consumed one week prior to illness onset.

Food Product	Yes	No	Unk	If Yes, Describe
Home canned, jarred, or preserved food products				*Describe*
Fermented food products				*Describe*
Dried or smoked fish products				*Describe*
Marinated food products				*Describe*
Suspicious commercial products (i.e. bulging lids or cans, recalled products, "off-odor" food items)				*Describe*

EXPOSURES / RISK FACTORS - SPECIFIC FOOD ITEMS

Provide information regarding any suspected food item consumed one week prior to illness onset.

Suspect Food Item 1

Food Item | *Date Eaten (mm/dd/yyyy)* | *Time Eaten (HH:MM AM/PM)*

Type of Food
☐ Homemade ☐ Restaurant associated ☐ Commercial product ☐ Unk

If commercial product, specify
Brand:_______________ Lot:_____________

How was food stored?
☐ Unrefrigerated ☐ Refrigerated ☐ Frozen ☐ Unk ☐ Other:________________

How was food preserved?
☐ Canned ☐ Dried ☐ Fermented ☐ Salted ☐ Pickled ☐ No preservation method ☐ Unk ☐ Other:_______________

How was food item served?
☐ Unheated ☐ Only warmed ☐ Microwaved ☐ Heated ☐ Boiled ☐ Fried ☐ Unk ☐ Other:_________________

Number of Persons who Shared the Food Item | *Number of Persons Ill*

Samples of food item available? ☐ Yes ☐ No ☐ Unk
Samples submitted for botulism testing? ☐ Yes ☐ No ☐ Unk
Foods of same batch / lot recovered or recalled? ☐ Yes ☐ No ☐ Unk

Suspect Food Item 2

Food Item | *Date Eaten (mm/dd/yyyy)* | *Time Eaten (HH:MM AM/PM)*

Type of Food
☐ Homemade ☐ Restaurant associated ☐ Commercial product ☐ Unk

If commercial product, specify
Brand:_______________ Lot:_____________

How was food stored?
☐ Unrefrigerated ☐ Refrigerated ☐ Frozen ☐ Unk ☐ Other:________________

How was food preserved?
☐ Canned ☐ Dried ☐ Fermented ☐ Salted ☐ Pickled ☐ No preservation method ☐ Unk ☐ Other:_______________

How was food item served?
☐ Unheated ☐ Only warmed ☐ Microwaved ☐ Heated ☐ Boiled ☐ Fried ☐ Unk ☐ Other:_________________

Number of Persons who Shared the Food Item | *Number of Persons Ill*

Samples of food item available? ☐ Yes ☐ No ☐ Unk
Samples submitted for botulism testing? ☐ Yes ☐ No ☐ Unk
Foods of same batch / lot recovered or recalled? ☐ Yes ☐ No ☐ Unk

EXPOSURES / RISK FACTORS - OTHER POTENTIAL EXPOSURES OF INTEREST

Exposure 1	*Describe*
Exposure 2	*Describe*

First three letters of patient's last name: | | | |

TRAVEL HISTORY (INCUBATION PERIOD IS 7 DAYS PRIOR TO ILLNESS ONSET)

*Did patient travel **outside county of residence** during the **incubation period**?* ☐ Yes ☐ No ☐ Unk	*If Yes, specify all locations and dates below.*

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*

CONTACTS / OTHER ILL PERSONS

Any contacts with similar illness? ☐ Yes ☐ No ☐ Unk	*If Yes, specify details below.*

ILL CONTACTS - DETAILS

Name 1	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	
Name 2	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*
Date First Reported to Public Health (mm/dd/yyyy)		*First Reported by* ☐ Clinician ☐ Laboratory ☐ Other (specify): ________________	

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unk	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION

Case Classification (see case definition below)
☐ Confirmed ☐ Probable ☐ Suspect

First three letters of patient's last name: ☐☐☐

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unk	*If Yes, extent of outbreak:* ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unk ☐ Other (specify):____________	
Vehicle of Outbreak	*Pattern 1 ID number*	*Pattern 2 ID number*

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Need additional information

CASE DEFINITION

BOTULISM, FOODBORNE (2011)

CLINICAL DESCRIPTION
Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

LABORATORY CRITERIA FOR DIAGNOSIS
- Detection of botulinum toxin in serum, stool, or patient's food, or
- Isolation of *Clostridium botulinum* from stool

CASE CLASSIFICATION
Probable: a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)
Confirmed: a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory confirmed botulism

BOTULISM, WOUND (2011)

CLINICAL DESCRIPTION
An illness resulting from toxin produced by *Clostridium botulinum* that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

LABORATORY CRITERIA FOR DIAGNOSIS
- Detection of botulinum toxin in serum, or
- Isolation of *Clostridium botulinum* from wound

CASE CLASSIFICATION
Probable: a clinically compatible case in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms
Confirmed: a clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms

BOTULISM, OTHER (2011)

CLINICAL DESCRIPTION
See Botulism, Foodborne.

LABORATORY CRITERIA FOR DIAGNOSIS
- Detection of botulinum toxin in clinical specimen, or
- Isolation of *Clostridium botulinum* from clinical specimen

CASE CLASSIFICATION
Confirmed: a clinically compatible case that is laboratory confirmed in a patient aged greater than or equal to 1 year who has no history of ingestion of suspect food and has no wounds

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

OCCUPATION SETTING

- Childcare / Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor / actress
- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory / seasonal worker
- Agriculture - other / unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other / unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - server
- Food service - other / unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other / unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent / guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other / unknown
- Teacher / employee - preschool or kindergarten
- Teacher / employee - elementary or middle school
- Teacher / employee - high school
- Teacher / instructor / employee - college or university
- Teacher / instructor / employee - other / unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other / unknown
- Volunteer
- Other
- Refused
- Unknown