

Attachment 6
10-day Post-exposure Questionnaire

**Form Approved
OMB No. 0920-0527
Exp. Date**

TELEPHONE INTERVIEW 10-14 DAYS FOLLOWING INITIAL INTERVIEW

Hello, this is _____ calling from (name of institution). May I speak with (Name of Contact Person from initial interview)?

About ___ days ago we spoke with you at (name of recreational area) and asked if you (your child/children) had been in the water on that day. We told you we'd be calling back to ask about your (your child/children) health. Is this a good time to talk?

I'll be reading a list of symptoms or health problems and want to know if you or anyone else in the family who was in the water that day has experienced them. If you've had any of the symptoms, I'll also ask about when they started and ended and if you've taken any medicine or seen a doctor about them.

Interviewer Initials:_____

Date:_____

Since your visit to (Recreational area), have you experienced any of the following symptoms or problems?

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| Symptom or Problem | When did it start? | When did it end? | Do you still have the symptom or problem? |
|--|---|---|---|
| First I have a list of some general health symptoms. | | | |
| Fever Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Chills Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Headache Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Sore throat Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Ear ache Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Discharge or fluid running from ear Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |

| Symptom or Problem | When did it start? DD MM YY | When did it end? DD MM YY | Do you still have the symptom or problem? |
|--|--------------------------------|--------------------------------|---|
| Abdominal pain | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Nausea | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Vomiting | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Diarrhea | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Diarrhea with blood | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Other (specify)_____ | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Now, I have a few questions about eye symptoms | | | |
| Blurred Vision Y | DK R | DK R | Y |

| Symptom or Problem | When did it start? ____ / ____ / DD MM YY | When did it end? ____ / ____ / DD MM YY | Do you still have the symptom or problem? N DK R |
|--|---|---|---|
| Irritation or pain Y N DK R | DK R ____ / ____ / DD MM YY | DK R ____ / ____ / DD MM YY | Y N DK R |
| Redness or discharge from eyes Y N DK R | DK R ____ / ____ / DD MM YY | DK R ____ / ____ / DD MM YY | Y N DK R |
| Conjunctivitis Y N DK R | DK R ____ / ____ / DD MM YY | DK R ____ / ____ / DD MM YY | Y N DK R |
| Other eye problems (specify) _____ Y N DK R | DK R ____ / ____ / DD MM YY | DK R ____ / ____ / DD MM YY | Y N DK R |

Now I have a few questions about breathing-related symptoms

| | | | |
|-------------------------------------|-----------------------------------|-----------------------------------|-------------------|
| Cough or choke Y N DK R | DK R ____ / ____ / DD MM YY | DK R ____ / ____ / DD MM YY | Y N DK R |
| Shortness of breath Y N DK | DK R ____ / ____ / | DK R ____ / ____ / | Y N DK |

| Symptom or Problem | When did it start? DD <u> </u> MM <u> </u> YY | When did it end? DD <u> </u> MM <u> </u> YY | Do you still have the symptom or problem? R |
|--|--|--|--|
| R | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | R |
| Nasal congestion or runny nose | DK R <u> </u> / <u> </u> / | DK R <u> </u> / <u> </u> / | Y N DK R |
| Y N DK R | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | |
| Throat irritation | DK R <u> </u> / <u> </u> / | DK R <u> </u> / <u> </u> / | Y N DK R |
| Y N DK R | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | |
| Other (specify) <hr/> Y N DK R | DK R <u> </u> / <u> </u> / | DK R <u> </u> / <u> </u> / | Y N DK R |
| | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | |

Thank you. Now, I have some questions about problems you might have with your nerves

| | | | |
|-------------------|---------------------------------|---------------------------------|-------------------|
| Agitation | DK R <u> </u> / <u> </u> / | DK R <u> </u> / <u> </u> / | Y N DK R |
| Y N DK R | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | |
| Confusion | DK R <u> </u> / <u> </u> / | DK R <u> </u> / <u> </u> / | Y N DK R |
| Y N DK R | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | |
| Dizziness | DK R <u> </u> / <u> </u> / | DK R <u> </u> / <u> </u> / | Y N DK R |
| Y N DK R | DD <u> </u> MM <u> </u> YY | DD <u> </u> MM <u> </u> YY | |

| Symptom or Problem | When did it start? DD MM YY | When did it end? DD MM YY | Do you still have the symptom or problem? |
|-----------------------|--------------------------------|--------------------------------|---|
| Lethargy | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Loss of consciousness | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Weakness | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Seizures | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Numbness | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |
| Tremor | DK R ____/____/ DD MM YY | DK R ____/____/ DD MM YY | Y N DK R |

Great. Now, just a few questions about skin problems.

| Symptom or Problem | When did it start? | When did it end? | Do you still have the symptom or problem? |
|---|--|--|---|
| Itchy skin Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Red skin Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Hives or welts Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Skin irritation/pain Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Rash (describe) _____ Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Infected cuts or scrapes Y N DK R | DK R ____/____/ DD <u> </u> MM <u> </u> YY | DK R ____/____/ DD <u> </u> MM <u> </u> YY | Y N DK R |
| Other (specify) _____ Y N DK | DK R ____/____/ ____ | DK R ____/____/ ____ | Y N DK R |

| Symptom or Problem | When did it start? DD MM YY | When did it end? DD MM YY | Do you still have the symptom or problem? |
|--------------------|--------------------------------|------------------------------|---|
| R | | | |

Thank you, that's all. We appreciate you being a part of the study.