**Follow-up Questionnaire for Asymptomatic Passengers and Crew, MERS CoV Aircraft Contact Investigation**

**Identifying and Residency Information (complete from 1st questionnaire)**

Passenger’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flight Information**:** Date:\_\_\_\_/\_\_\_\_/14 Destination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attempt(s) to reach passenger**

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Time | Outcome (circle one) | Message left/e-mail sent |
|  |  | Interview completed / not completed |  |
|  |  | Interview completed / not completed |  |
|  |  | Interview completed / not completed |  |
|  |  | Interview completed / not completed |  |
|  |  | Interview completed / not completed |  |

Name of person answering the questions (if not traveler): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of person answering questions (if not traveler):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of interview: (\_\_\_\_/\_\_\_\_/14)

Agency/Affiliation of Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Follow-up for asymptomatic contacts** [should be 14 days since the flight and will likely be less than 14 days from the date initially interviewed]

**Script:**

Thank you for agreeing to this follow-up call from (circle one): CDC/Health Department.

We are calling you to find out if you have become sick since our last conversation and if you saw a doctor.

Are you willing to answer a few questions? YES NO

If NO, thank the person for their time.

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You flew on \_\_\_/\_\_\_/14. Fourteen days after this time period is [today’s date or state other date].This 14-day period is the monitoring period.

**A. Illness History**

1. Have you been ill since we last spoke with you? **** Yes **** No

***IF YES, go to question #2. IF NO, thank the person for their time.***

2. Have you had any of the following symptoms?

*Specify date of onset in mm/dd/yy format for each Yes answer.*

1. **Fever (measured temp of > 100.40 F (380 C)** **** Yes (\_\_\_\_\_°) Temp if known **** No **** Don’t Know
2. **Coughing** **** Yes **** No **** Don’t Know
3. **Difficulty breathing** **or shortness of breath ** Yes **** No **** Don’t Know
4. **Wheezing**  **** Yes **** No **** Don’t Know
5. **Pain with coughing or breathing ** Yes **** No **** Don’t Know
6. Other symptom(s): **** Yes List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**** No **** Don’t Know

**If NO to 2. a-e, END.**

3. What date did you first become ill with these symptoms? Date\_\_\_\_/\_\_\_\_/14

4. Are you still sick? **** Yes **** No

4a. If NO, when did you feel better? Date\_\_/\_\_/14

5. Did you see a doctor for this illness? **** Yes **** No

**If YES**,

* 1. What date were you seen? Date\_\_/\_\_/14
  2. Did you receive any treatment for the illness? **** Yes **** No
     1. If YES, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  3. Were you tested by a medical provider for the illness (including, but not limited to, providing a blood sample or nasal or throat swab) since the day of your flight [insert date of flight]? **** Yes **** No
     1. If YES – Specify test or what kind of specimen was tested for you (e.g., blood, nasal swab, throat swab): \_\_\_\_\_\_\_
        1. Date (mm/dd/yy) \_\_\_\_/\_\_\_\_/14
        2. Facility where tested\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  4. Were you admitted to the hospital (kept overnight, not just in emergency room)? **** Yes **** No If yes, which hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Do you have any medical conditions that you are treated for regularly?

**** Yes (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_) **** No **** Don’t Know

7. For women: Are you currently pregnant? **** Yes **** No **** Don’t Know

**B. GEOGRAPHIC EXPOSURES**

8. Have you visited the Middle East since [insert date **that is 14 days before** the flight date]\*?

**** Yes **** No **If NO, skip to Question 27.**

1. If YES : Dates of visit (mm/dd/yy) \_\_\_/\_\_\_\_/14 to \_\_\_/\_\_\_\_\_/14
2. List country(ies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. (Omit for crew) What was the purpose of your trip? (check all that apply)

**** Visit family/friends **** Personal travel **** Business **** Study ****Other; specify: \_\_\_\_\_

9. While you were in the Middle East, did you:

1. Have any close contact with someone who was sick with the MERS coronavirus? **** Yes **** No
2. Have any close contact with someone who was sick with a serious respiratory infection, such as pneumonia? **** Yes **** No

b. Visit a health care facility? **** Yes **** No

c. (Omit for crew) Work in a health care facility? **** Yes **** No

**Household Contacts**

10. Has anyone in your household or someone else you have had close contact with had fever, cough, difficulty breathing (or symptoms similar to what you described)?

**** Yes \*\*\* **** No **** Don’t Know

* 1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\* Note this person’s name and contact information on the form for follow-up by local health department.

***IF FEVER PLUS ANY RESPIRATORY SYMPTOMS (2 b-e).***

* **If ill person has not received health care, read symptomatic contact script.**
* **Send completed questionnaire to the health department*.***

***CONSULT MEDICAL OFFICER IF FEVER ALONE OR WITH ONLY “OTHER” SYMPTOMS, OR RESPIRATORY SYMPTOMS WITHOUT FEVER.***

**THE END**

**Script:** Thank you for taking the time to answer these questions.

Do you have any questions for me?