

Interview Form

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Study ID: _____

Streptococcus pneumoniae Meningitis Outbreak Questionnaire

Revised: February 17, 2009

Today's Date (month, day, year) ____/____/2009
 Initials of person completing form: _____

1. Identifying information		CASE ID: _____																														
Name																																
<i>Last</i>		<i>First</i>		<i>Middle Initial</i>																												
Date of Birth: __ / __ / __ m m / d d / y y		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone number for home of record _____ Building _____ Floor _____ How many recruits sleep in your room? _____																												
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		Do you have an allergy to penicillin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what was the reaction? <input type="checkbox"/> Rash <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Other (specify) _____																														
Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																																
2. Symptoms, Signs and Significant Conditions																																
Since February 1, have you had:		Start date: mm/dd/yyyy	Still have symptom?	If no, end date mm/dd/yyyy																												
Fever (subjective)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
If yes, sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Blood in sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Stiff neck	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Unexplained muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Chills/shakes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Red / draining eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Earache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
Other unexplained symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___																												
<p>February 2009</p> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td> </tr> <tr> <td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td> </tr> <tr> <td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td> </tr> <tr> <td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td> </tr> </table> <p>You may use this calendar to help you remember dates.</p>					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
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8	9	10	11	12	13	14																										
15	16	17	18	19	20	21																										
22	23	24	25	26	27	28																										

Past Medical History (Check All That Apply):

- Pneumonia in past year Recurrent ear infections or sinus infections
 Diabetes Tuberculosis (if yes, Latent Active)
 Asthma Other _____
 History of leukemia or lymphoma _____

Are you currently pregnant? (if male, please check "no") yes no

- Have you smoked at least 100 cigarettes in your life (100 cigarettes = approximately 5 packs)
 yes no

If YES, do you smoke now: everyday some days not at all

In the last thirty days did you drink any alcohol? yes no unknown

Did you drink more than 5 drinks in a week? yes no unknown

Have you received any of the following vaccines:

Influenza (since August 2008): Yes No Unknown

If yes, (month/year) ___ / ___ AND Type Shot Nasal Mist

Pneumococcal (pneumonia vaccine): Yes No Unknown If yes, (month/year) ___ / ___

3. Treatment

Since February 1, have you:

Visited a medical infirmary or medical clinic on post Yes No (if **no**, skip to section 6)

If yes, Visit date: ___ / ___ / ___

Reason for visit: _____

Diagnosis: ear infection pneumonia bronchitis

sinusitis cold/upper respiratory infection meningitis

conjunctivitis other _____

Did you receive treatment?: Yes No

If yes, what treatment: _____

Been admitted to a hospital Yes No

If yes, hospital name, city, state: _____

Admission date: ___ / ___ / ___

Discharge date: ___ / ___ / ___

Reason for admission: _____

Diagnosis: pneumonia bronchitis sinusitis

cold/ upper respiratory infection meningitis

other _____

Received antimicrobial? Yes No Unknown

If yes, please check the antibiotic(s) you were administered (check all that apply):

Azithromycin Augmentin

Levofloxacin Penicillin

Oseltamivir (Tamiflu) Zanamivir

Other (specify) _____

Antimicrobial #1:

Reason for antibiotic: _____

Start date: ___ / ___ / ___

Was it a shot or pill? Shot Pill

If pill, total # of days antibiotic taken: _____

Did you complete full course? Yes No Unknown

Antimicrobial #2:

Reason for antibiotic: _____

Start date: ___ / ___ / ___

Was it a shot or pill? Shot Pill

If pill, total # of days antibiotic taken: _____

Did you complete full course? Yes No Unknown

Study ID: _____

4. Lab Testing

Since February 1, have you had any of the following tests performed?

Sputum/phlegm: Yes No Unknown If yes, date ___/___/_____
Nose swab: Yes No Unknown If yes, date ___/___/_____
Blood draw: Yes No Unknown If yes, date ___/___/_____
Urine sample: Yes No Unknown If yes, date ___/___/_____
Lumbar puncture/spinal tap: Yes No Unknown If yes, date ___/___/_____
Other: _____ If yes, date ___/___/_____

5. Radiological Testing

Since February 1, have you had any of the following tests performed?

Chest X-ray: Yes No If yes, where: _____ Date ___/___/_____
Chest CAT scan or MRI: Yes No If yes, where: _____ Date ___/___/_____
Head CAT scan or MRI: Yes No If yes, where: _____ Date ___/___/_____

6. Exposure History

Since February 1, have you shared a room or been in close contact with anyone who has had meningitis?
 Yes No Unknown

Since February 1, have you shared a room or been in close contact with anyone else who has been ill?
 Yes No Unknown

If yes, have they been coughing? Yes No Unknown
Did they go to the health clinic or hospital for care? Yes No Unknown
Have they been diagnosed with pneumonia? Yes No Unknown

How can we contact you for follow-up: Permanent Address: _____

6. For Investigator Use Only (DO NOT WRITE BELOW THIS LINE)

Has this person had (FEVER + 2 or more respiratory symptoms) in the past 72 hours?: Yes No
If yes to the above question, check which of the following was obtained:
 NP bacterial swab Check the type that was used: Copan Dacron
 NP viral swab Check the type that was used: Copan Dacron
 OP viral swab

Patient received (check all that apply):
 PPV 23 vaccine
 Penicillin G
 Azithromycin
 Ceftriaxone

Notes:

Prospective Pneumonia Surveillance Form

