

## 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: _____																														
<b>Name</b>																																
<i>Last</i>		<i>First</i>		<i>Middle Initial</i>																												
<b>Date of Birth:</b> __ / __ / __ m m / d d / y y		<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone number for home of record _____ Building _____ Floor _____ How many recruits sleep in your room? _____																												
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		<b>Do you have an allergy to penicillin?</b> <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) _____																														
<b>Hispanic or Latino:</b> <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>					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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<p><b>You may use this calendar to help you remember dates.</b></p>																																

**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*

16256

Case ID#

□□□□□□

Date (MM/DD/YYYY)

□□/□□/□□□□

Last Name:

□□□□□□□□□□□□□□

First Name:

□□□□□□□□□□□□

Company:  Alpha  Hotel  Cadre for Alpha  Cadre for Hotel

Platoon:  First  Second  Third  Fourth Class: □□□□□□

On what floor of the barracks do you live? □□ How many trainees sleep in your room? □□

Today I Have:

Fever:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Coughing up Blood:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Coughing up Mucus:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Difficulty Breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Runny Nose:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Sore Throat:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Chest Pain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Head Ache:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Stiff Neck:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Muscle Aches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Chills/Shakes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Rash:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Diarrhea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□
Red Eyes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date started (MM/DD/YYYY):	□□/□□/□□□□

Clinician Use Only

Vitals: Temp: □□□ RR: □□□ O2 Sat: □□□

Currently taking antibiotics prescribed before today's visit:  Yes  No

If yes, date started (MM/DD/YYYY): □□/□□/□□□□

Name of Antibiotic: □□□□□□□□□□□□□□

Brief description of chest x-ray:

Hospitalized today:  Yes  No Antibiotics/Antivirals prescribed today:  Yes  No

If yes, name of antibiotic: □□□□□□□□□□□□□□

Check which testing was obtained:

Rapid Flu Test If done results:  Flu A  Flu B  Negative

Nasopharyngeal swab collected for viral testing

Oropharyngeal Swab Collected If done results:  Flu A  Flu B  Negative