Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Interview Form

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** _____ *Last* _____ *First* _____ *Middle Initial*

**Date of Birth:**
__ __ / __ __ / __ __
m m d d y y

**Sex:**
□ Male
□ Female

**Race:**
□ White □ Black □ Asian/Pacific Islander □ Unknown
□ Other _____

**Hispanic or Latino:**
□ Yes □ No □ Unknown

Phone number for home of record_____
Building_____
Floor _____
How many recruits sleep in your room?_____

**Do you have an allergy to penicillin?**
□ Yes □ No □ Unknown
If yes, what was the reaction?
□ Rash □ Difficulty breathing □ Other (specify) ____

## 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) | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Cough | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| If yes, sputum? | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Blood in sputum | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Difficulty breathing | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Wheezing | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Runny nose | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Sore throat | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Headache | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Stiff neck | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Seizures | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Unexplained muscle aches | □ Yes □ No | __/__/____ | □ Yes □ No | __/__/____ |
| Night sweats | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Chest pain | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Chills/shakes | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Diarrhea | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Rash | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Red / draining eyes | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Earache | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |
| Other unexplained symptoms | □ Yes □ No □ Unknown | __/__/____ | □ Yes □ No | __/__/____ |


**You may use this calendar to help you remember dates.**

Study ID: _____

**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: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Cough: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Coughing up Blood: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Coughing up Mucus: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Difficulty Breathing: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Runny Nose: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Sore Throat: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Chest Pain: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Head Ache: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Stiff Neck: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Muscle Aches: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Chills/Shakes: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Rash: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Diarrhea: | Yes | No | If yes, date started (MM/DD/YYYY): / / |
| Red Eyes: | Yes | 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