

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.

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.

- a. **Fever (measured temp of > 100.4°F (38°C))** Yes (____°) Temp if known No
 Don't Know
- b. **Coughing** Yes No Don't Know
- c. **Difficulty breathing or shortness of breath** Yes No Don't Know
- d. **Wheezing** Yes No Don't Know
- e. **Pain with coughing or breathing** Yes No Don't Know
- f. 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,

- a. What date were you seen? Date ___/___/14
- b. Did you receive any treatment for the illness? Yes No
 i. If YES, specify: _____
- c. 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
 i. 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 _____

d. 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.**

a. If YES : Dates of visit (mm/dd/yy) ___/___/14 to ___/___/14

b. List country(ies): _____

c. (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:

a. Have any close contact with someone who was sick with the MERS coronavirus? Yes
 No

b. 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 #: _____

2. 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?