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

ID Number _____

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 <u>asymptomatic</u> 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 <u>___/___/14.</u> Fourteen days after this time period is <u>[today's date or state other date]</u>.This 14-day period is the monitoring period.

ID Number _____

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 > 100.4^0 F (38^0 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 <u>before</u>** 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?