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