**Measles Case Control Study Questionnaire**

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| **MEASLES CASE CONTROL STUDY Questionnaire (last revised 5/30/14)** | **UNIQUE STUDY ID # (lab #?)# \_ \_ \_ \_ \_ \_ -\_**  [LAB #] [CASE CONTROL #] Case –control # [ CASE = 0 ; CONTROL 1 =1; CONTROL 2 =2; CONTROL 3 = 3] | | | | |
| REPORTING DATE (**CASE ONLY )**  (DAY/MONTH/YEAR) \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | | | | |
| DATE OF INTERVIEW/INVESTIGATION (DAY/MONTH/YEAR ) \_\_\_/\_\_\_\_/\_\_\_\_\_ | NAME OF INTERVIEWER: | | | Written consent  obtained | |
| INTERVIEW WITH: CASE  CONTROL | AGE: \_\_\_\_\_\_ years OR  \_\_\_\_\_\_\_ months  (if less than 12 months old) | | | DATE OF BIRTH  \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_  (DAY/MONTH/  YEAR) | |
| SEX : MALE  FEMALE |  | | | | |
| *START HERE: THANK YOU FOR AGREEING TO PARTICIPATE IN THE STUDY.* | | | | | |
| 1. WHO IS THE RESPONDENT | 1 – CASE/CONTROL THEMSELF  99 – OTHER (SPECIFY)\_\_\_\_\_\_\_\_\_\_ | | | | |
| 1. **EXPOSURE HISTORY** |  | | | | |
| 1. HAVE YOU (**CASE)** HAD CONTACT WITH A PERSON WITH RASH AND FEVER IN THE 1 TO 3 WEEKS BEFORE THE BEGINNING OF YOUR RASH ILLNESS? | 1 – YES GO TO QUESTION 4  2 – NO GO TO QUESTION 5  99 – UNKNOWN GO TO QUESTION 5 | | | | |
| 1. HAVE YOU (**CONTROL)** HAD CONTACT WITH A PERSON WITH RASH AND FEVER IN THE PREVIOUS 1- 3 WEEKS? | 1 – YES GO TO QUESTION 4  2 – NO GO TO QUESTION 6  99– UNKNOWN GO TO QUESTION 6 | | | | |
| 1. WHERE DID YOU (**CASE OR CONTROL**) HAVE CONTACT WITH THIS PERSON?   Choose all that apply | 1 – AT HOME  2 – AT WORK  3 – AT SCHOOL  4– HEALTH CENTER/HOSPITAL (SPECIFY) \_\_\_\_\_\_\_\_\_\_  5 – CHURCH/MOSQUE/TEMPLE  6 – PLAYING OUTSIDE  7– ON PUBLIC TRANSPORT  8 – OTHER \_\_\_\_\_\_\_\_\_\_  99 – UNKNOWN | | | | |
|  |  | | | | |
| 1. DID YOU **(CASE)** GO TO A HOSPITAL OR CLINIC 7 TO 21 DAYS BEFORE THE ONSET OF RASH ILLNESS ? | 1 – YES GO TO QUESTION 7  2 – NO GO TO QUESTION 12  99 – UNKNOWN GO TO QUESTION 12 | | | | |
| 1. DID YOU (**CONTROL)** GO TO A HOSPITAL OR CLINIC IN THE LAST 7 TO 21 DAYS?   (*THE 7-21 DAYS PRIOR TO THIS INTERVIEW)* | 1 – YES GO TO QUESTION 7  2 – NO GO TO QUESTION 12  99 – UNKNOWN GO TO QUESTION 12 | | | | |
| 1. HOW MANY TIMES DID YOU GO TO A HOSPITAL OR CLINIC? | 1 – ONCE GO TO QUESTION 8  2 – MORE THAN ONCE GO TO QUESTION 11 | | | | |
| 1. NAME OF THE HOSPITAL/CLINIC? |  | | | | |
| 1. WERE YOU ADMITTED TO THE HOSPITAL? | 1 – YES  2 – NO | | | | |
| 1. DATE OF VISIT | \_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  *IF THE EXACT DATE IS NOT KNOWN, WRITE THE INFORMATION GIVEN BY THE INTERVIEWEE* | | | | |
| 1. LIST THE DATES AND LOCATIONS OF ALL HOSPITAL/CLINIC VISITS IN THE LAST 7-21 DAYS? | | | | | |
| DATE | HOSPITAL/CLINIC NAME | | ADMITTED TO HOSPITAL ON THIS VISIT? | | |
| \_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | | 1 – YES  2 – NO | | |
| \_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | | 1 – YES  2 – NO | | |
| \_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | | 1 – YES  2 – NO | | |
| \_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | | 1 – YES  2 – NO | | |
| 1. HAVE YOU BEEN IN ANY DENSELY POPULATED INDOOR (CONGREGATED) SETTINGS IN THE LAST THREE WEEKS (SUCH AS KINDERGARTEN, SCHOOL, FACTORY OR DORMITORY) | 1 – YES GO TO QUESTION 13  2 – NO GO TO QUESTION 15  99 – UNKNOWN GO TO QUESTION 15 | | | | |
|  |  | | | | |
| 1. WHAT WAS THE CONGREGATED SETTING? Choose all that apply | 1 -KINDERGARTEN  2 – SCHOOL  3- FACTORY  4 – RELIGIOUS SERVICE  5 -PUBLIC TRANSPORTATION (SPECIFY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  6 –JAIL/PRISON  7- HOSPITAL  8 – GOVERNMENT BUILDING  9– DORMITORY  10 – WEDDING  11 – WORK PLACE  12– OTHER (SPECIFY \_\_\_\_\_\_\_\_\_\_\_\_) | | | | |
| ADDRESS OF CONGREGATED SETTING: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ADDRESS: \_\_\_\_\_\_\_COUNTRY/DISTRICT  \_\_\_\_\_\_\_ TOWNSHIP/STREET  \_\_\_\_\_\_\_\_ VILLAGE/NEIGHBORHOOD | | | | |
| 1. **VACCINATION STATUS** | | | | | |
| NOW I AM GOING TO ASK YOU SOME QUESTIONS RELATED TO VACCINATION | | | | | |
| 1. WERE YOU VACCINATED AGAINST MEASLES AS A CHILD? | | 1 – YES GO TO QUESTION 16  2 – NO GO TO QUESTION 17  99 – UNKNOWN GO TO QUESTION 17 | | | |
| 1. HOW MANY DOSES OF MEASLE VACCINE DID YOU RECEIVE AS A CHILD? | | 1 – ONE  2-TWO OR MORE  99– UNKNOWN | | | |
|  | |  | | | |
| 1. **INFORMATION ABOUT PLACE OF RESIDENCE AND TRAVEL HISTORY** | | | | | |
| **I AM GOING TO ASK YOU (CASE OR CONTROL) SOME QUESTIONS ABOUT YOUR TRAVEL HISTORY** | | | | | |
| 1. IN THE LAST 2 MONTHS HAVE YOU TRAVELED OUTSIDE OF KOSRAE (FOR ANY REASON)? |  | | | | |
| 1. HOW MANY TIMES IN THE LAST 2 MONTHS HAVE YOU TRAVELED OUSIDE OF KOSRAE? |  | | | | |
| 1. WHERE DID YOU TRAVEL TO? |  | | | | |
| 1. IN THE LAST 2 MONTHS HAS A MEMBER OF THE HOUSEHOLD TRAVELED OUTSIDE OF “X”? |  | | | | |
| 1. WHICH HOUSEHOLD MEMBER AND WHERE DID THEY GO TO? |  | | | | |
| 1. IN THE LAST 2 MONTHS HAVE YOUHAD CONTACT WITH ANYBODY FROM A FOREIGN COUNTRY? |  | | | | |
| 1. WHERE WAS THIS PERSON OR PEOPLE FROM? 2. **(LIST ALL APPOPRIATE RESPONSES)** |  | | | | |
| 1. WHERE DID YOU HAVE CONTACT WITH THIS PERSON? 2. **(LIST ALL APPOPRIATE RESPONSES)** |  | | | | |
|  |  | | | | |
| **SOCIODEMOGRAPHIC INFORMATION** | | | | | |
| *MY LAST QUESTIONS DEAL WITH YOUR HOUSEHOLD* | | | | | |
| 1. PLEASE LIST NAMES AND AGES OF ALL HOUSEHOLD MEMBERS | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | HH MEMBER | NAME | AGE | FEVER AND RASH IN LAST 3 MONTHS? (yes/no) | DATE OF ILLNESS | | 1 |  |  |  |  | | 2 |  |  |  |  | | 3 |  |  |  |  | | 4 |  |  |  |  | | 5 |  |  |  |  | | 6 |  |  |  |  | | 7 |  |  |  |  | | 8 |  |  |  |  | | 9 |  |  |  |  | | 10 |  |  |  |  | |
| 1. HOW MANY PEOPLE SLEEP IN THE SAME ROOM AS YOU? |  | | | |
| 1. DO YOU HAVE ANY CHILDREN? |  | | | |
| 1. HOW MANY CHILDREN DO YOU HAVE? |  | | | |
| HOW OLD IS THIS CHILD/CHILDREN? |  | | | |
| DOES THIS CHILD/ CHILDREN LIVE WITH YOU? |  | | | |
| WHICH ETHNIC GROUP DO YOU BELONG TO? |  | | | |
| WHAT RELIGION DO YOU PRACTICE? |  | | | |
| 1. WHAT IS YOUR LEVEL OF SCHOOLING |  | | | |
| 1. WHAT IS THE LEVEL OF SCHOOLING OF YOUR MOTHER? |
| WHAT IS THE LEVEL OF SCHOOLING OF YOUR FATHER? |  | | | |
| 1. WHAT IS YOUR OCCUPATION? |  | | | |

SIGNATURE OF SUPERVISOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF VERIFICATION BY SUPERVISOR\_\_\_/\_\_\_/\_\_\_