

Case-Control Study Questionnaire for the Investigation of Guillain-Barré Syndrome in Relation to Arboviral Infections

Study ID Number BR- ____ - ____ Case Control

The ID number begins with the 2 digit case number (for example BR01) followed by an "A" for the case patient, a "B" for the first control, a "C" for the second control, and a "D" for the third control. For example, the second control subject matched for case number 8 would be labeled "BR-08-C."

Interviewer: _____ Date of Interview: ____/____/____
DD MM YYYY

Neuro Symptom Onset Date for Case ____/____/____
DD MM YYYY

The following questions are to be asked of cases AND controls during the interview:

1. Current Address: _____/_____/_____
(Street) (Town) (Province) (District)

2. Onset Address: _____/_____/_____
(for cases only if different from above; where cases spent most nights in the 2 months prior to neuro onset)

3. GPS Coordinates (Onset for cases; current for controls): _____. _____ S, _____. _____ E

4. Sex: Male Female

5. Race: White Hispanic Indigenous Black/African decent Other: _____

6. Age when cases developed first neuro symptoms (or equivalent date for controls): _____ Years

7. What is your occupation? _____

8. Have you been told by a clinician that you have any of the following medical conditions?

Diabetes High blood pressure Heart disease High cholesterol

Stroke Kidney disease Liver disease

Rheumatologic disease

Asthma COPD Cancer Surgery (within 2 months of symptom onset)

Other neurologic illness: _____

Take any medication or have any condition that might impact your ability to fight infections (e.g. prednisone):

9. a. In the 2 months prior to ____/____/2015 (neuro onset date for case), have YOU been sick at all?

Yes No Unknown

b. If so, when did you first feel sick? ____/____/____

c. If so, what symptoms did you have (check all that apply)?

Fevers Chills Nausea or Vomiting Diarrhea
 Muscle pains Joint pains Skin rash Abnormally red eyes
 Headache Pain behind eyes Stiff neck Confusion

Abdominal pain Coughing Runny nose Sore throat Calf pain

d. If so, did you see a doctor or go to the hospital for this illness? Yes No Unknown

Which doctor? _____ Which hospital? _____

e. If so, did they draw any blood for testing? Yes No Unknown

10. a. In the 2 months prior to __ __ / __ __ / ____ (neuro onset date for case), has anyone in your HOUSEHOLD been sick at all? Yes No Unknown

b. If so, when did the first household member become sick? __ __ / __ __ / ____

c. If so, what symptoms did any household members have (check all that apply)?

Fevers Chills Nausea or Vomiting Diarrhea
 Muscle pains Joint pains Skin rash Abnormally red eyes
 Headache Pain behind eyes Stiff neck Confusion
 Abdominal pain Coughing Runny nose Sore throat Calf pain

11. a. Have you received any vaccinations in 2015? Yes No Unknown

b. If so, which vaccine and date? _____ __ __ / __ __ / ____

Information verified on vaccine card Information provided verbally

c. If so, which vaccine and date? _____ __ __ / __ __ / ____

Information verified on vaccine card Information provided verbally

12. In 2015, what pets, farm, or other animals have lived in your house or on your property (check all that apply)?

Dogs Cats Mice/rats Pet birds Pet lizards /turtles
 Goats Sheep Cows Chickens Pigs Other _____

13. In 2015, how often have you gotten your drinking water from the tap?

Almost always (>75%) Often (25-75%) Rarely (<25%) Never (0%)

14. In 2015, how often have you gotten your drinking water from a well or river/stream/pond?

Almost always (>75%) Often (25-75%) Rarely (<25%) Never (0%)

15. In 2015, how often do you walk around barefoot?

Almost always (>75%) Often (25-75%) Rarely (<25%) Never (0%)

16. In 2015, have you swam or waded in a freshwater river, stream, or pond?

Daily Weekly Monthly Rarely (<once per month) Never

17. In 2015, do you recall being bit by a mosquito? Yes No Unknown

18. In 2015, have you handled any dead animals? Yes No Unknown

Which? _____

19. In 2015, have you eaten or drank any of the following foods at least once per week (check all that apply)?

- | | | | | |
|-------------------------------|---------------------------------|----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Beef | <input type="checkbox"/> Lamb | <input type="checkbox"/> Chicken | <input type="checkbox"/> Fish | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Milk | <input type="checkbox"/> Cheese | <input type="checkbox"/> Yogurt | <input type="checkbox"/> Fresh salad / uncooked greens | |