Form Approved
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SOUTHERN ARIZONA HOUSEHOLD DENGUE INVESTIGATION

INDIVIDUAL INTERVIEW FORM

Specimen Label

Complete one form for each consenting individual in the household.

1. Case Patient ID # - Individual #: _____-_____

2. Your name / Nombre: _____
First (given) Middle Last

3. How long have you been living in Arizona? *Cuánto tiempo ha estado viviendo en el sur de Tejas?* _____ years

4. Have you used mosquito repellent in the past three months? *Ha usado repelente de mosquitos en los últimos tres meses?* □Yes □ No

5. Have you traveled outside of the country, for example to Mexico, in the past three months? *Ha viajado usted fuera del país, por ejemplo a México, en los últimos 3 meses?*
□Yes □ No □ Do not recall/no me acuerdo

5a. If yes, specify when and where (start with most recent) – *Si ha viajado, especifique donde y cuando (comenzando con el mas reciente)*:

	Travel destination / *Destino del viaje* (City, Country)	**Dates of Travel / *Fechas del viaje* (e.g. Dec 2012–Jan 2013)**	**Duration of travel / *Duración del viaje* (weeks)**
Country 1			
Country 2			
Country 3			
Country 4			
Country 5			

6. Have you had a fever in the last three months? ***Ha tenido usted fiebre en los últimos tres meses?*** ☐ Yes ☐ No ☐ Don't know

6a. First day of fever –*primer dia con fiebre* (MM/DD/YYYY**): _____/_____/_____**

6b. Did you seek medical attention (e.g. doctor, pharmacist, healer, etc.)? *Buscó usted atención médica (doctor, farmaceútico, curandero, etc.)?* ☐ Yes ☐ No

6b-1. If yes, what is the name of the health care facility where you sought care? (*Si busco ayuda médica, cual es el nombre del lugar?)*

_____

6b-2. Where is the health care facility located? (*Dónde está localizado este personal medico?)*

City, State _____, _____

☐ United States ☐ Mexico ☐ Other

6b-3. If yes, what was the diagnosis? *(Cuál fue el diagnostico?)*

☐ Flu ☐ Dengue ☐ Typhus */Tifo murino* ☐ West Nile */ Fiebre del Nilo*

☐Other: _____ ☐Don't know

6b-4. Were you hospitalized for this illness? ***Estuvo usted hospitalizado por esta enfermedad?*** ☐ Yes ☐ No

6b-4a. Duration of hospitalization/ *Duración de la hospitalización*:
_____ days

6b-4b. Hospital Name/ *Nombre del hospital*: _____

6c. During your illness, did you have any of the following:

	Yes	No	Unknown	Comments
Headache */Dolor de la cabeza*				
Body/muscle pain */Dolor del cuerpo o los musculos*				
Eye pain/ Dolor de los ojos				
Rash */Erupcion de la piel*				
Lethargy */Letargo*				
Anorexia				
Nausea/vomiting */Nausea/vomitando*				
Dizziness resulting in fainting/*Mareos que resultan en desmayos*				
Severe persistent abdominal pain */Dolor abdominal severo y persistente*				
Persistent vomiting (≥3 times in 1 day) / *Vómito persistente*				
Bruising / *Moretones*				
Nose Bleeding / *Sangrado nasal*				
Bleeding from gums */Sangrado en las encías*				
Blood in vomitus / *Sangrado en el vómito*				
Blood in urine / *Sangrado en la orina*				
Blood in stool / *Sangrado en la excreta*				
Black, tarry stools / *Excreta negra*				
Heavy vaginal bleeding / *Sangrado vaginal excesivo*				

(To be completed by the laboratory.)

Dengue Duo Test Results (check all that are positive)**:**

□ RT-PCR □ IgM □ None □ Not done

If rt-PCR-positive, DENV type identified: □ DENV-1 □ DENV-2 □ DENV-3 □ DENV-4

Date specimen tested (MM/DD/YYYY): _____ /_____ /_____ Tested by: _____

Comments: