Form Approved
OMB No. 0920-XXXX
Exp. Date XX/XX/2016

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

Study ID Number PR- ____ ____ - ____ ☐ Case ☐ Control

The ID number begins with the 2 digit case number (for example PR01) followed by an "A" for the case patient, a "B" for the first control, and a "C" for the second control. For example, the second control subject matched for case number 8 would be labeled "PR-08-C."

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

Neuro Symptom Onset Date for Case __ __ /__ __ /_____
MM DD YYYY

Insert onset date into questions 10 and 11.

This questionnaire was conducted on: ☐ Directly with case or control ☐ Indirectly

If indirectly, with whom?:_____

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

Background and Demographics

1. Current Address: _____/_____
(Street) (Municipality)

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. a) Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

b) Race (may select more than one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Decline to answer

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

7. What is your occupation? _____

8. What form of health insurance do you have? ☐ Reforma/SSS ☐ Private ☐ Veteran's ☐ Other ☐ None

Medical History

8. Have you ever 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 ☐ Cancer ☐ Chronic obstructive pulmonary disease (COPD)
☐ Surgery (within 2 months of date of symptom onset) ☐ Other neurologic illness:_____

9. Do you take any medication (e.g., prednisone) or have any condition that might impact your ability to fight infections (e.g., immunological disorder):

☐ Yes ☐ No If yes, please list: _____

10. a). In the 2 months prior to __ __ /__ __ / 2016 (neuro onset date for case), have YOU been sick at all?
MM DD YYYY

☐ Yes ☐ No ☐ Unknown

b.) If so, when did you first feel sick? __ __ /__ __ /_____
MM DD YYYY

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

f.) If so, was any other bodily fluids tested? ☐ Yes ☐ No ☐ Unknown

If yes, which? ☐ Urine ☐ Saliva ☐ Other_____

11. a.) In the 2 months prior to __ __ /__ __ / 2016 (neuro onset date for case), has anyone in your HOUSEHOLD been sick at all?
MM DD YYYY

☐ Yes ☐ No ☐ Unknown

b.) If so, when did the first household member become sick? __ __ /__ __ /_____
MM DD YYYY

c.) If so, what symptoms did this household member 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

12. I would like to ask you some questions about vaccination. Do you have a vaccination record available?

☐ Yes and shown to interviewer ☐ Yes but not shown ☐ Information provided verbally

13. Which vaccinations have you received and when?

a.) In the last 2 months, did you receive the influenza vaccine? ☐ Yes ☐ No

If yes, when? _____

b) Which other vaccinations have you received?

	MM DD YYYY	
i.) MMR	__ __/__ __/_____	Additional doses: _____
ii.) Polio	__ __/__ __/_____	_____
iii.) Yellow fever	__ __/__ __/_____	_____
iv.) BCG	__ __/__ __/_____	_____
v.) DTaP	__ __/__ __/_____	_____
vi.) HIB	__ __/__ __/_____	_____
vii.) Pneumococcal	__ __/__ __/_____	_____
viii.) Meningitis	__ __/__ __/_____	_____
ix.) Hep B	__ __/__ __/_____	_____
x.) Zoster/Shingles	__ __/__ __/_____	_____

x.) Other vaccines (e.g. rabies, Japanese encephalitis, etc.):

Which? _____ __ __/__ __/_____

Behavior and Environmental Exposures

For the remaining questions, I will ask about practices and behaviors over the past two months. Please think back over the past 2 months when answering to them.

14. What pets or other animals (e.g., farm animals) have lived in your house or on your property (check all that apply)?

☐ Dogs ☐ Cats ☐ Mice/rats ☐ Pet birds ☐ Reptiles/amphibians

☐ Goats ☐ Sheep ☐ Cows ☐ Chickens ☐ Pigs

☐ Other _____

15. How often have you gotten your drinking water from the tap?

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

If ever, was the water boiled or treated? ☐ Yes ☐ No ☐ Unknown

16. 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%)

If ever, was the water boiled or treated? ☐ Yes ☐ No ☐ Unknown

17. How often do you walk around barefoot outside?

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

18. Have you swam or waded in a freshwater river, stream, or pond?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely (<once per month) ☐ Never

19. How much time do you spend outdoors each day?

☐ <1 hour ☐ 1–4 hours ☐ 5–8 hours ☐ >8 hours

20. Do you recall being bitten by a mosquito? ☐ Yes ☐ No ☐ Unknown

21. Do you normally wear insect repellant when outside?

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

22. Do you leave the windows open at your house?

☐ Yes, during the day ☐ Yes, at night ☐ Yes, all times ☐ Windows are not left open at this house

23. How many of your windows or doors have intact screens?

☐ All of them ☐ Some of them ☐ None of them

24. Does your home use any of the following for air conditioning?

☐ Central air conditioning ☐ Local air conditioning (1–2 room) ☐ None

25. How often do you have sources of standing water around the outside of your house (e.g. buckets, water storage/cistern, septic tank, pond)?

☐ Daily ☐ 2–3 times/week ☐ Once/week ☐ Every other week ☐ Never

26. Have you slaughtered animals and/or handled any dead animals?

☐ Yes ☐ No ☐ Unknown

If yes, which? _____

27. Have you eaten or drunk any of the following foods at least once per week (check all that apply)?

☐ Beef ☐ Lamb ☐ Chicken ☐ Fish ☐ Shellfish

☐ Milk ☐ Cheese ☐ Yogurt ☐ Fresh salad /uncooked greens

28. Did you eat any of the following foods raw or undercooked (check all that apply)?

☐ Beef ☐ Lamb ☐ Chicken ☐ Shellfish ☐ Fish (including ceviche)