Unique ID _____

Form Approved
OMB Control No. 0920-xxxx
Exp. Date xx/xx/20xx

3 and 6 Month Follow-Up Questionnaire for Men

Section A: *To be completed by the Receptionist*

1 Unique Study ID: □□□□□□□□

First, I would like to ask you if your contact information has changed since your last visit. If someone else answers the phone, we will not tell them any information about the study. I would like to remind you that your involvement in the study is completely confidential.

2 Address of residence: _____

3 Village of residence: _____

4 District of residence: _____

5 Telephone: _____

6 Other contact/next of kin: _____

CHECKED BY RECEPTIONIST:

Signature: _____ Date: **(DD/MM/YYYY)** _____/_____/_____

Unique ID _____

Section B: *To be completed by the Nurse*

Thank you for participating in this study. I will be conducting your interview today and it will last about 10 minutes. I ask all participants in this study the same questions. All of your answers are confidential. I will mark a response to every question, but if you are not comfortable answering any question, you can tell me to mark "no answer". You can also ask me to go back, or repeat any questions. Are you comfortable proceeding with the interview now?

Now, I would like to ask you a few questions about the time since we last saw you.

7 How is your overall health and wellbeing now, ***compared to your last study visit***?

01 - My overall health now is the same as how I felt at my last study visit
02 - My overall health now is worse than how I felt at my last study visit
03 - My overall health now is better than how I felt at my last study visit
88 – Don't know
99 - Refused

8 ***Since your last study visit***, do you have any **new** health problems?

01 - Yes
02 - No **SKIP TO 9**
88 - Don't know/not sure **SKIP TO 9**
99 - Refused **SKIP TO 9**

9 If yes, please specify the new health problems you are experiencing. **MARK ALL THAT APPLY.**

Symptom	Yes	No	Refused
General (*fevers, weight loss, loss of appetite, feeling tired*)	☐	☐	☐
Eye problems (*itching, ocular redness, eye lid inflammation, blurred vision, complete loss of vision*)	☐	☐	☐
Joint problems	☐	☐	☐
Abdominal Pain	☐	☐	☐
Headache	☐	☐	☐
Neurological (*loss of strength in arms, or legs, inability to balance*)	☐	☐	☐
Skin problems (itching, spots)	☐	☐	☐
Psychiatric problems (hallucinations, delusions)	☐	☐	☐
Psychological problems (depression, anxiety)	☐	☐	☐
Other (e.g. loss of hair) SPECIFY _____	☐	☐	☐

Unique ID _____

10 ***Since your last study visit***, have you been hospitalized for any serious illness?

01 - Yes
02 - No **SKIP TO 10**
88 - Don't know/not sure **SKIP TO 10**
99 - Refused **SKIP TO 10**

10a What were the symptoms that you had?

SPECIFY: _____

10b When did you go to the hospital?
(DD/MM/YYYY) ____ / ____ / _____ □ Estimated

10c How many days did you stay at the hospital? □□ □ Estimated

10d Which hospital did you go to?

SPECIFY: _____

10e What was your diagnosis?

SPECIFY: _____

10f What treatment did you receive?

SPECIFY: _____

11 ***Since your last study visit***, has anyone in your household or any of your close contacts (*such as sexual partners or family*) gotten Ebola?

01 - Yes
02 - No **SKIP TO 11**
88 - Don't know/not sure **SKIP TO 11**
99 - Refused **SKIP TO 11**

12 If yes, please specify their relationship to you, and if they recovered or died.
Nurses should capture information on sexual partners, siblings, and children. If more than one spouse, sibling or child, please list one per row.

No.	Relationship	Outcome	

Unique ID _____

		Recovered	*Died*	*Refused*			
1		☐	☐	☐			
2		☐	☐	☐			
3		☐	☐	☐			
4		☐	☐	☐			
5		☐	☐	☐			
6		☐	☐	☐			
7		☐	☐	☐			

13 ***Since our last meeting***, have you participated in sexual activity? Sexual activity includes oral, vaginal, or anal sex.

01 - Yes
02 - No **SKIP TO 14**
99 - Refused **SKIP TO 14**

14 If yes, how often did you use a condom during sex? **Choose one.**

01 - Never
02 - Some of the time
03 - Every time
88 - Don't know
99 - Refused

15 How often have you engaged in sexual activities ***since your last visit***?

01 - Every day
02 - 3 or more time a week
03 - 2 times a week
04 - Once per week
05 - Once per month
06 - Once
88 - Don't know
99 – Refused

16 *Since your last visit*, did you make any women pregnant?

01 - Yes
02 - No
88 - Don't know/not sure
99 – Refused

16a If Yes, how many times have you made a woman pregnant since your last visit?

☐☐_____☐ estimated

Unique ID _____

15 Thank you very much for participating in the survey today. Do you have any other comments or concerns you would like to share about these topics?

16 Result of questionnaire:

01 - Completed
02 - Partially completed
03 - Participant refused
04 - Other → Specify: _____

CHECKED BY NURSE:

Signature _____ Date: _____/_____/_____
(DD / MM / YYYY)

CHECKED BY RESEARCH ASSISTANT:

Signature _____ Date: _____/_____/_____
(DD / MM / YYYY)