

Unique ID _____

Follow Up Visit 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) ____/____/____

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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 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

8 If yes, please specify the new health problems you are experiencing.

MARK ALL THAT APPLY.

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

9 Since our last meeting, has anyone in your home/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

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10 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. Write “refused” under relationship if participant refuses to specify relationship.*

No.	Relationship	Outcome			Did this person have Ebola before or after you		
		<i>Recovered</i>	<i>Died</i>	<i>Refused</i>	<i>Before</i>	<i>After</i>	<i>Refused</i>
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 *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**

12 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

13 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

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

01 - Yes

02 - No

88 - Don't know/not sure

99 - Refused

14a If yes, how many times have you made a woman pregnant since your last visit?

estimated

Mark 99 if refused

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)