Unique ID _____

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

Follow Up Visit Questionnaire for Women

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 ***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 (*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 _____	☐	☐	☐

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**

Unique ID _____

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?**		
		Recovered	*Died*	*Refused*	*Before*	*After*	*Refused*
1		☐	☐	☐	☐	☐	☐
2		☐	☐	☐	☐	☐	☐
3		☐	☐	☐	☐	☐	☐
4		☐	☐	☐	☐	☐	☐
5		☐	☐	☐	☐	☐	☐
6		☐	☐	☐	☐	☐	☐

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 13**
99 - Refused **SKIP TO 13**

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
99 - Refused

14 Since the last visit, have you stopped breastfeeding? **Choose one.**

01 - Yes
02 - No **SKIP TO 16**
99 - Refused **SKIP TO 16**

Unique ID _____

15 If you stopped breastfeeding, why? **MARK ALL THAT APPLY**

01 - I ran out of/stopped producing breast milk
02 - I was worried about infecting my baby with Ebola
03 - My husband/partner/family member/community leader told me not to breastfeed
04 - My doctor told me not to breastfeed.
05 - My child was old enough to wean
06 - Other → SPECIFY: _____
88 - Don't know
99 - Refused

16 Since your last visit, have you started your menstrual period?

01 - Yes
02 - No **SKIP TO 17**
03 - Other → SPECIFY _____ **SKIP TO 17**
88 - Don't know/not sure **SKIP TO 17**
99 - Refused **SKIP TO 17**

16a If yes, when was the first day of your period?

First day of bleeding: (DD/MM/YYYY) ____ / ____ / _____ □ Estimated
If refused date, put 99/99/9999

17 Do you know if you are pregnant today?

01 - Yes, I am pregnant
02 - No, I am not pregnant today. **SKIP TO 18**
88 - Don't know/not sure **SKIP TO 18**
99 - Refused **SKIP TO 18**

To all women: We will also offer you the possibility of a pregnancy test as a part of this study; you can accept or decline the test as you like.

17a If you are pregnant today, how many months pregnant are you? □□ □ Estimated
If refused, mark 99

18 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?

19 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)