

## 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 / <i>Destino del viaje</i> (City, Country)	Dates of Travel / <i>Fechas</i> <i>del viaje</i> (e.g. Dec 2012-Jan 2013)	Duration of travel / <i>Duración del</i> <i>viaje</i> (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 día con fiebre* (MM/DD/YYYY): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

6b. Did you seek medical attention (e.g. doctor, pharmacist, healer, etc.)? *Buscó usted atención médica (doctor, farmacéutico, 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?)*

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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 / <i>Dolor de la cabeza</i>				
Body/muscle pain / <i>Dolor del cuerpo o los musculos</i>				
Eye pain/ <i>Dolor de los ojos</i>				
Rash / <i>Erupcion de la piel</i>				
Lethargy / <i>Letargo</i>				
Anorexia				
Nausea/vomiting / <i>Nausea/vomitando</i>				
Dizziness resulting in fainting/ <i>Mareos que resultan en desmayos</i>				
Severe persistent abdominal pain / <i>Dolor abdominal severo y persistente</i>				
Persistent vomiting (≥3 times in 1 day) / <i>Vómito persistente</i>				
Bruising / <i>Moretones</i>				
Nose Bleeding / <i>Sangrado nasal</i>				
Bleeding from gums / <i>Sangrado en las encías</i>				
Blood in vomitus / <i>Sangrado en el vómito</i>				
Blood in urine / <i>Sangrado en la orina</i>				
Blood in stool / <i>Sangrado en la excreta</i>				
Black, tarry stools / <i>Excreta negra</i>				
Heavy vaginal bleeding / <i>Sangrado vaginal excesivo</i>				

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**(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: