Form Approved
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Case-Control Study Questionnaire for the Investigation of Guillain-Barré Syndrome in Relation to Arboviral Infections

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

BR- ____ ____ - ____

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

The ID number begins with the 2 digit case number (for example BR01) followed by an "A" for the case patient, a "B" for the first control, a "C" for the second control, and a"D" for the third control. For example, the second control subject matched for case number 8 would be labeled "BR-08-C."

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

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

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

1. Current Address: _____/_____/_____/_____
(Street) (Town) (Province) (District)

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. Race: ☐ White ☐ Hispanic ☐ Indigenous ☐ Black/African decent ☐ Other:_____

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

7. What is your occupation? _____

8. Have you 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 ☐ COPD ☐ Cancer ☐ Surgery (within 2 months of symptom onset)

☐ Other neurologic illness:_____

☐ Take any medication or have any condition that might impact your ability to fight infections (e.g. prednisone):

_____

9. a. In the 2 months prior to __ __ /__ __ /2015 (neuro onset date for case), have YOU been sick at all?

☐ Yes ☐No ☐ Unknown

b. If so, when did you first feel sick? __ __ /__ __ /_____

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

10. a. In the 2 months prior to __ __ /__ __ /_____ (neuro onset date for case), has anyone in your HOUSEHOLD been sick at all? ☐ Yes ☐ No ☐ Unknown

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

c. If so, what symptoms did any household members 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

11 a. Have you received any vaccinations in 2015? ☐ Yes ☐No ☐ Unknown

b. If so, which vaccine and date? _____ __ __ /__ __ /_____

☐ Information verified on vaccine card ☐ Information provided verbally

c. If so, which vaccine and date? _____ __ __ /__ __ /_____

☐ Information verified on vaccine card ☐ Information provided verbally

12. In 2015, what pets, farm, or other animals have lived in your house or on your property (check all that apply)?

☐ Dogs ☐ Cats ☐ Mice/rats ☐ Pet birds ☐ Pet lizards /turtles

☐ Goats ☐ Sheep ☐ Cows ☐ Chickens ☐ Pigs ☐ Other _____

13. In 2015, how often have you gotten your drinking water from the tap?

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

14. In 2015, 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%)

15. In 2015, how often do you walk around barefoot?

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

16. In 2015, have you swam or waded in a freshwater river, stream, or pond?

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

17. In 2015, do you recall being bit by a mosquito? ☐Yes ☐No ☐Unknown

18. In 2015, have you handled any dead animals? ☐Yes ☐No ☐Unknown

Which? _____

BR- ____ ____ - ____

19. In 2015, have you eaten or drank 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