Form Approved
OMB No. 0920-1011
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Section 1: INTERVIEWER INFORMATION *(Questions 1-5 to be completed by interviewer prior to questionnaire administration)*

1. Subject ID: _____ 2. Inmate #: _____
3. Date of Interview: __ __ / __ __ / __ __ __ __ *(if unknown, enter 99/99/9999)* (M M / D D / Y Y Y Y)
4. Interviewer Information Name: _____
   Agency or Organization: _____
5. Location of interview:_____
6. Respondent was: ☐ Self ☐ Family ☐ Clinician ☐ Other (Specify):_____
7. Respondent is: ☐ Confirmed case ☐ Suspected case ☐ Not a case ☐ Other (Specify):_____

QUESTIONNAIRE FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*, JUNE 2016

Section 2: DEMOGRAPHIC DATA:

1. Birth month and year __ __ / __ __ __ __ *(if unknown, enter 99/9999)* (M M / Y Y Y Y)
2. Sex: ☐ Male ☐ Female ☐ Unknown
3. Hispanic or Latino origin? ☐ Yes ☐ No ☐ Unknown
4. How would you describe your race? ☐ White ☐ Black/ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other (specify): _____ ☐ Unknown
5. What is your cell/ward location in the prison:_____
6. What are your prison duties or job (kitchen staff, lawn crew, janitorial):_____

Section 3: FOOD ALLERGIES, SPECIAL DIETS:

Yes	Maybe	No	Don't Know	Did you have:
☐	☐	☐	☐	1. Any allergies that prevent you from eating a certain food(s)?
				1a. What foods? *Please check all that apply*. ☐ Milk ☐ Eggs ☐ Peanuts ☐ Tree nuts ☐ Fish ☐ Soy ☐ Wheat ☐ Shellfish ☐ other: _____
☐	☐	☐	☐	2. Do you follow any of the following special or restricted diets?
				☐ Dairy-free ☐ Vegetarian/Vegan ☐ Kosher ☐ Gluten-free ☐ Other religious diet:_____ ☐ Other:_____

Section 4 Comments. *Please fill in any comments/notes from this section in the space provided below:*

Section 4: SOURCES OF FOOD:

1. In the past two week, did you eat foods from?

☐ Prison cafeteria	☐ Food brought to you in the prison by friend or relatives
☐ Food prepared in cell	☐ Food shared from other prisoners
☐ Prison shop	☐ Food bought or traded from other prisoners
☐ Other:_____	

3. **In the past two weeks have you stored food in your cell?**
☐ Yes ☐ No

4. **In the past two weeks have you consumed food prepared in your cell?**
☐ Yes ☐ No

Section 5: FOOD ITEMS:

5. Did you eat any of the follow food items served in the prison cafeteria?:
*** To be completed with prison food menu.

Food item	Yes	No	Don't know	Unknown

Have you eaten any additional food items in the past two weeks?:

Section 4 Comments. *Please fill in any comments/notes from this section in the space provided below:*

Section 6: HOOCH: Now I have a few questions about Hooch or Pruno.

Yes	Maybe	No	Don't Know	
☐	☐	☐	☐	1. Have you ever drank hooch since you entered the prison?
				1a. How often do you drink hooch? ☐ daily ☐ weekly ☐ monthly ☐ less than monthly ☐ when it is available ☐ don't know
☐	☐	☐	☐	2. Have you drank hooch since June 1st?
				2a. How many times did you drink hooch since June 1st? _____ 2b. When did you first drink the hooch? __ __ / __ __ / __ __ __ __ 2c. On average, how much hooch did you drink each time? ☐ a sip ☐ a cup ☐ a pint ☐ more than a pint ☐ Other:_____ 2d. Did you share with other people? ☐ Yes ☐ No ☐ Don't know How many people did you share with? _____ Are any of these people currently sick?_____ 2e. Do you still have hooch in your cell? ☐ Yes ☐ No ☐ Don't know 2f. Where did you get the hooch?_____ 2g. Do you know when the batch of hooch that you made was dug up or first drank? ☐ Yes ☐ No ☐ Don't know If yes, when? __ __ / __ __ / __ __ __ __

Section 4 Comments. *Please fill in any comments/notes from this section in the space provided below:*

Section 7: CLINICAL INFORMATION:.

1. What date did you first feel sick? __ __ / __ __ / __ __ __ __ *(if unknown, enter 99/99/9999)* ☐ Not sick
   M M D D Y Y Y Y
2. How many days total were you sick? _____ days *(enter 999 if unknown)* or ☐ Still Ill

Yes	No	Don't Know	Was the patient:
☐	☐	☐	3. Hospitalized overnight?
			Date of hospitalization __ __ / __ __ / __ __ __ __
			Date of discharged __ __ / __ __ / __ __ __ __ or ☐ Still hospitalized
			Admitted to ICU? ☐ Yes ☐ No ☐ Don't know
☐	☐	☐	4. Intubated?
			Date of intubation __ __ / __ __ / __ __ __ __
			Date stopped intubation __ __ / __ __ / __ __ __ __ or ☐ Still Intubation
☐	☐	☐	5. Did patient receive HBAT
			Date of HBAT administration __ __ / __ __ / __ __ __ __

Did the patient have any of the following symptoms:

Yes	No	Don't Know	Symptom
☐	☐	☐	Change in sound of voice
☐	☐	☐	Abdominal Pain
☐	☐	☐	Hoarseness
☐	☐	☐	Diarrhea
☐	☐	☐	Dry mouth
☐	☐	☐	Constipation
☐	☐	☐	Dysphagia (difficulty swallowing)
☐	☐	☐	Blurred Vision
☐	☐	☐	Shortness of breath
☐	☐	☐	Diplopia (double vision)
☐	☐	☐	Subjective weakness
☐	☐	☐	Dizziness
☐	☐	☐	Fatigue
☐	☐	☐	Slurred Speech
☐	☐	☐	Paresthesia (abnormal sensation, e.g. numbness)
☐	☐	☐	Thick tongue
☐	☐	☐	Nausea
☐	☐	☐	Extraocular Palsy (paralysis of eye muscles)
			If yes, is it bilateral?
			If bilateral, is it symmetric?
☐	☐	☐	Ptosis (drooping eyelids)
☐	☐	☐	Facial Paralysis
			If yes, is it bilateral?
			If bilateral, is it symmetric?
☐	☐	☐	Palatal weakness

			If yes, is it bilateral?
☐	☐	☐	Impaired gag reflex
☐	☐	☐	Other sensory deficit(s)
			Which ones?_____
☐	☐	☐	Other symptoms?
			Which ones?_____

Clinical history:

Yes	No	Don't Know	Comorbidity
☐	☐	☐	HIV
☐	☐	☐	TB
☐	☐	☐	Hepatitis C
☐	☐	☐	Hypertension
☐	☐	☐	Diabetes
☐	☐	☐	Other Comorbidity(ies)?
			Which other(s)?_____