**Undetermined source for Salmonella Infantis infections among**

**detention center inmates — South Carolina, 2016**

**CASE INTERVIEW FORM**

**CDC ID:** **[ ] [ ] [ ] [ ]  Date:** [ ] [ ] /[ ] [ ] /[ ] [ ]   **Data collector** **initials: \_\_\_\_\_**

1. Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Unit:**
3. **DOB:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]
4. **When was the first documented episode of diarrhea:** [ ] [ ] /[ ] [ ] /[ ] [ ] [ ] [ ]

**Foodborne disease outbreak questionnaire (Prison A)** Interviewer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Interviewer information** *(Questions 1-4 to be completed by interviewer prior to questionnaire administration)* |
| 1. PulseNet ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Required)** | 1. State/Local/Other ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 1. Date of Interview:
 | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ *(if unknown, enter 99/99/9999)**M M D D Y Y Y Y* |
| 1. Interviewer Information Contact phone number: **(\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_**

Agency or Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Stool sample: Yes/No      Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Part I. Demographics:**

|  |  |  |
| --- | --- | --- |
| 1. Age: \_\_\_\_\_ Sex\_\_\_\_\_(M/F)
 | 1. Race (check all that apply)

[ ] American Indian or Alaska Native [ ] Asian[ ] Black or African American [ ] White[ ] Native Hawaiian/other Pacific Islander [ ] Unknown[ ] Other race | 1. Ethnicity:

[ ]  Hispanic or Latino[ ]  Not Hispanic or Latino[ ]  Unknown |

1. Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Bed#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In Isolation: Yes / No
2. When were you admitted to this detention center? Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. What work do you perform at this detention center? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Where do you perform this work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you help in the kitchen or handle food? Yes / No

**Part II. Clinical information**

1. Have you had any symptoms of gastrointestinal illness during the week of July 10th, 2016? Yes / No
2. What day did your symptoms begin: \_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (example: Tuesday MM/DD/YY)
3. *Please circle when you began feeling sick:*

 1 AM 7 AM 1 PM 7 PM

 2 8 2 8

 3 9 3 9

 4 10 4 10

 5 11 5 11

 6 AM 12 Noon 6 PM 12 Midnight

1. Did you have any of the following symptoms during the week of July 10th, 2016?:

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom** | **Yes/No/Unknown** | **Onset Date** | **Notes** |
| Nausea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Vomiting | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | If yes, what is the largest number of episodes you had in a 24 hour period ? \_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Diarrhea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Bloody Diarrhea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | If yes, what is the largest number of episodes you had in a 24 hour period ? \_\_\_\_\_\_\_\_\_\_\_\_\_ Did you provide a stool sample? [ ] Yes [ ] No |
| Fever | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | Highest temperature, if measured \_\_\_\_\_\_[ ] °C or [ ] °F  |
| Chills | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Headache | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Abdominal pain/cramping | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Body aches | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Fatigue/Tiredness | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Dizziness | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Other:\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ | XYes | \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ |  |

1. Have your symptoms stopped? Yes / No
2. If yes, when did your symptoms end? Date\_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Did you seek medical care at the infirmary or go to sick call? Yes / No
	1. When? Date\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time\_\_\_\_:\_\_\_\_ AM/ PM
4. Did you receive intravenous (IV) fluids? Yes / No
5. Did you receive any medications? Yes / No 9a) If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Were you hospitalized for this illness? Yes / No
7. When were you admitted to the hospital? Date\_\_\_\_ / \_\_\_\_ / \_\_\_\_
8. When did you return from the hospital? Date\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Part III. Food:**

|  |  |  |
| --- | --- | --- |
|  | Did you eat in the cafeteria on this day? | Did you eat an alternate meal? |
| Saturday, July 9 | Yes No | Yes NoIf yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sunday, July 10 | Yes No | Yes NoIf yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Monday, July 11 | Yes No | Yes NoIf yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tuesday, July 12 | Yes No | Yes NoIf yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Wednesday, July 13 | Yes No | Yes NoIf yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please place an X next to any food item you ate on any of these days:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Saturday, July 9** | **Sunday, July 10** | **Monday, July 11** | **Tuesday, July 12** | **Wednesday, July 13** |
| **Breakfast** |   | **Breakfast** |   | **Breakfast** |   | **Breakfast** |   | **Breakfast** |   |
|   |   |   |   | Grits |   | Fruit Drink |   | Oatmeal |   |
|   |   |   |   | Biscuit |   | Oatmeal |   | Breakfast sausage |   |
|   |   |   |   | Sausage |   | Scrambled Eggs |   | Pancake square |   |
|   |   |   |   | Gravy |   | O'Brien potatoes |   | Margarine |   |
|   |   |   |   | Lyonnaise Potatoes |   | Biscuit |   | Maple syrup |   |
|   |   |   |   | Margarine |   | Margarine |   | Dairy Drink |   |
|   |   |   |   | Dairy Drink |   | Jelly |   | Cornbread |   |
|   |   |   |   |   |   | Dairy Drink |   |   |   |
|   |   |   |   |   |   |   |   |   |   |
| **Lunch** |   | **Lunch** |   | **Lunch** |   | **Lunch** |   | **Lunch** |   |
|   |   |   |   | Turkey Bologna |   | Cheese Slice |   | Ham? |   |
|   |   |   |   | Creamy Cole Slaw |   | Turkey Salami |   | Italian Pasta Salad |   |
|   |   |   |   | Bread |   | Marinated Vegetable Salad |   | Bread |   |
|   |   |   |   | Mustard |   | Bread |   | Mustard |   |
|   |   |   |   | Cookie Square |   | Mustard |   | Cookie Square |   |
|   |   |   |   | Fruit Drink |   | Cookie Square |   | Fruit Drink |   |
|   |   |   |   |   |   | Fruit Drink |   |   |   |
|   |   |   |   |   |   |   |   |   |   |
| **Dinner** |   | **Dinner** |   | **Dinner** |   | **Dinner** |   | **Dinner** |   |
|   |   |   |   | Italian Meat Sauce |   | Chili Con Carne |   | Meatloaf |   |
|   |   |   |   | Spaghetti Noodles |   | Plain rice |   | ? |   |
|   |   |   |   | Seasoned Green Beans |   | Seasoned Cabbage |   | Fluffy Rice |   |
|   |   |   |   | Garlic Bread |   | Cornbread |   | Mixed Beans |   |
|   |   |   |   | ? |   | Margarine |   | Cornbread |   |
|   |   |   |   | Sweat tea |   | ? |   | ? |   |
|   |   |   |   |   |   | Sweet Tea |   | Frosted Chocolate Cake |   |
|   |   |   |   |   |   |   |   | Sweet tea |   |

Now, I will ask you more questions about what you ate and drank during the week of July 10th. Try to remember and answer as best as you can.

Please circle or specify any other food-related items that you ate:

ice spread mayonnaise other condiments

Other specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was any of the food you ate undercooked? Yes / No / DK

If yes, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you eat any food not provided by the cafeteria? Yes / No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, where was that food obtained?

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you drink any beverages not provided by the cafeteria? Yes / No

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, where was that drink obtained?

If yes, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you eat any leftover food from previous days? Yes / No

If yes, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, do you remember when you obtained that food? \_\_\_\_\_/\_\_\_\_\_\_ (MM/DD)

Did you prepare any food in your barracks (e.g. “spread”)? **Yes / No**

If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you eat the food that you prepared in your barracks? Yes / No

Date of preparation \_\_\_\_/\_\_\_\_\_ (MM/DD)

Date of consumption \_\_\_\_/\_\_\_\_\_ (MM/DD)

Did you share the food that you prepared in your barracks with anyone else? Yes / No

If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food allergies? **Yes/No**

If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods that you do not eat? **Yes/No**

If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you typically eat? Breakfast \_\_\_\_\_\_\_\_AM Lunch \_\_\_\_\_\_\_AM / PM Dinner: \_\_\_\_\_\_\_\_ PM

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part IV. Handwashing Practices**

How many times per day do you usually wash your hands? \_\_\_\_\_\_\_\_\_\_\_\_

Describe the times of day when you wash your hands. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part V. Medical History:**

**Do you have any of the following conditions?** *(check all that apply)* [ ] None [ ] Unknown

|  |  |
| --- | --- |
| [ ] Asplenia[ ] Autoimmune disease[ ] Cancer, any (incl. leukemia/lymphoma)[ ] Chronic kidney disease (with or without dialysis)[ ] Chronic liver disease (incl. cirrhosis)[ ] Chronic pulmonary disease (incl. COPD/emphysema, asthma)[ ] Congestive heart failure[ ] Connective tissue disease[ ] Diabetes mellitus[ ] Gastroesophageal reflux disease (GERD)[ ] HIV/AIDS | [ ] Ischemic heart disease/Myocardial infarction/Peripheral vascular dz[ ] IV drug use in past year[ ] Peptic ulcer disease[ ] Pregnancy (current)[ ] Prosthetic device or vascular graft[ ] Recurrent cystitis or urinary tract infection[ ] Sickle cell disease[ ] Smoking in past year[ ] Transplant (incl. solid organ, hematopoietic stem cell, bone marrow)[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Part VI. Notes:** *(Add any comments not specifically asked on questionnaire)*

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