

## **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: \_\_\_\_\_

<b>INTERVIEWER INFORMATION</b> (Questions 1-4 to be completed by interviewer prior to questionnaire administration)	
1. PulseNet ID #: _____ <b>(Required)</b>	2. State/Local/Other ID #: _____
3. Date of Interview:        ____ / ____ / ____ (if unknown, enter 99/99/9999) M M D D Y Y Y Y	
4. Interviewer Information	Contact phone number: (____) _____ - _____
Agency or Organization: _____	
5. Stool sample: Yes/No    Result: _____	

**Part I. Demographics:**

6. Age: _____ Sex _____ (M/F)	7. Race (check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Other race	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown	8. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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9. Unit: \_\_\_\_\_ Cell#: \_\_\_\_\_ Bed# \_\_\_\_\_ In Isolation: Yes / No

10. When were you admitted to this detention center?        Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

11. What work do you perform at this detention center? \_\_\_\_\_

12. Where do you perform this work? \_\_\_\_\_

13. 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 10<sup>th</sup>, 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

4. Did you have any of the following symptoms during the week of July 10<sup>th</sup>, 2016?:

Symptom	Yes/No/Unknown	Onset Date	Notes
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	If yes, what is the largest number of episodes you had in a 24 hour period? _____
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Bloody Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	If yes, what is the largest number of episodes you had in a 24 hour period? _____ Did you provide a stool sample? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	Highest temperature, if measured _____ <input type="checkbox"/> °C or <input type="checkbox"/> °F
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Abdominal pain/cramping	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Body aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Fatigue/Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___/___	
Other: _____	xYes	___/___/___	

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

12. 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                  No If yes, describe: _____ _____ _____
Sunday, July 10	Yes                  No	Yes                  No If yes, describe: _____ _____ _____
Monday, July 11	Yes                  No	Yes                  No If yes, describe: _____ _____ _____
Tuesday, July 12	Yes                  No	Yes                  No If yes, describe: _____ _____ _____
Wednesday, July 13	Yes                  No	Yes                  No If 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	
<b>Breakfast</b>		<b>Breakfast</b>		<b>Breakfast</b>		<b>Breakfast</b>		<b>Breakfast</b>	
				Grits		Fruit Drink		Oatmeal	
				Biscuit		Oatmeal		Breakfast sausage	
				Sausage		Scrambled Eggs		Pancake square	
				Gravy		O'Brien potatoes		Margarine	
				Lyonnais Potatoes		Biscuit		Maple syrup	
				Margarine		Margarine		Dairy Drink	
				Dairy Drink		Jelly		Cornbread	
						Dairy Drink			
<b>Lunch</b>		<b>Lunch</b>		<b>Lunch</b>		<b>Lunch</b>		<b>Lunch</b>	
				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			
<b>Dinner</b>		<b>Dinner</b>		<b>Dinner</b>		<b>Dinner</b>		<b>Dinner</b>	
				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	
				Sweet 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 10<sup>th</sup>. 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

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

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

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