

ID# _____
(home / survey number)

Self-Report Health Questionnaire & Risk Factor Survey

Complete one per student

Name of Interviewer: _____

Date of Interview: _____

Place of Interview: _____

Name of Interviewee: _____

Home Address: _____

Interviewee's information

1. Age: _____
2. Sex: 1- Male 2- Female



Household information

3. How many people live in the house? _____

Please complete the following table for each person that lives at this address:

Name	Relation to the Head of the Household	Age	Sex	Occupation/Student

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1. What is the occupation of the head of the household?
2. What is the highest educational degree achieved?

No School Elementary or Less Middle School
 High School University Post Graduate

3. How long has your family lived at this location?

- a. If less than 10 years, where did you move from? (address)

4. How many bedrooms are there in the house?

5. Do you own the house?

Yes No, the home is rented
 Living with friends Living with family
 Other (explain) _____

Water usage

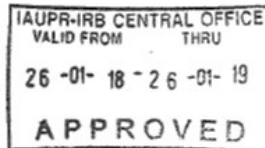
6. How often do you drink from the tap without boiling the water?

Always Most of the time
 Sometimes Never

7. Do you treat the water before drinking it? Yes No

- a. If yes, please explain how.

with filter by boiling
 with chlorine other method



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8. Do you have any problems with your drinking water? Yes No

If yes, which of the following happened?

- bad odor bad taste
 cloudy color
 other (explain) _____

9. Do you drink water at school? Yes No

If yes, which?

- drinking fountain bottled water
 tap water other

10. Do you drink water from other sources? Yes No

If yes, which?

- bottled water river water
 rain water other

Sanitation

11. Does your home have access to any of the following?

- toilet discharging into a sewage system toilet discharging into a septic tank
 latrine toilet discharging into a river or land
 other (explain) _____

12. If you have septic tank, how often is emptied?

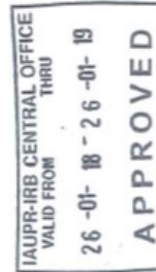
- never once a year or less
 more than once a year

13. Are there problems with your septic tank? Yes No

- leaks bad odor
 other (explain) _____

14. Do you own any of these pets or farm animals?

- dogs cats pigs
 chickens ducks cows



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Daily Report Card Study ID Number _____

Participant: _____

First Name _____

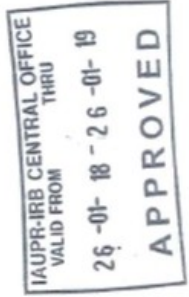
Last Name _____

Date: / /

Please note any symptoms experienced during trips you made for each day of the week.

Day	Had any symptoms?										Were you traveling?			
	Diarrhea			Diarrhea w/ blood		Vomiting (feeling sick)	Stomach ache/pain or cramping	Nausea (feeling sick)	Headache	Fever or chills	Cough, nasal congestion, sore throat, or throat infection	No symptoms	Abroad (outside the US)	Did not travel
Monday	1	2	3+	1	2	3+	1	2	3+					
Tuesday														
Wednesday														
Thursday														
Friday														
Saturday														
Sunday														

If you experience diarrhea or vomiting this week, please complete questions 1 through 12 of the Extended Daily Record



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Comprehensive report card		Study ID number	
Participant: First Name _____ Last Name _____		Date	Month Year
Please note if you experienced vomiting or diarrhea during the week, before completing this questionnaire.			
As a result of the symptoms listed on the daily report card		No	Yes
1. Did you visit the doctor?			
2. Have you contacted a doctor in another manner?			
3. Did you consult with a nurse or a doctor?			
4. Did you call a 24-hour medical care facility (Urgent Care)?			
5. Did you go to the Health Services Center?			
6. Did you go to an Emergency Room?			
7. Were you hospitalized for this condition?			
a. How many days did you spend?	<input type="text"/>		
8. Were you hospitalized during the night?			
9. Was a stool sample taken?			
a. What were the results of the analysis?	<input type="text"/>		
10. Did you take any medication for the symptoms?			
a. <input type="checkbox"/> over the counter <input type="checkbox"/> with prescription			
b. What was the name of the medicine?			
11. Are you taking any antibiotic medications?			
12. Are you taking probiotic supplements or eating probiotic foods prepared by bacterial fermentation like yogurt?			
13. Do you suffer from chronic disease (lasting > 6 months)?			
14. Do these symptoms require that a family member miss work or attend school?			
a. Total days of work missed due to symptoms	<input type="text"/>		
b. Total days of school missed due to symptoms	<input type="text"/>		
		What do you think caused the disease? Please mark one box below Medicine (i.e. antibiotic, steroids) Person to person contact (transmission) Alcohol Food Poisoning Drinking water at the house Contact with water or consumed from another location Pregnancy or Menstruation Contact with Animals Chemotherapy or Radiation Recent stomach or intestinal surgery Intestinal Disorder Unknown Infection Other (Explain) Unknown	

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APPROVED

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Consent Form

If you want to be part of the health study, please print your name and **school name** and then sign and date in the boxes shown below. Parents or guardians must sign on behalf of children under the age of twelve (12). If you are under 21 years of age, please sign the document and have your parent or guardian sign the document as a witness to your signature. If you (or a family member or friend) would like more information about this study, please do not hesitate to contact Graciela Ramirez Toro at 787-264-1912 ext. 7630, 7631.

I confirm that I read the information sheet on this study and I have the opportunity to ask questions. I agree to take part in the health study.

Name of Student Participant	Signature	Date	School Name
	X _____		
Name of Student Participant's Parent (If student is less than 21 years old)	Signature	Date	
	X _____		

