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

ID#_____
(home / survey number)

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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ID#_____
(home / survey number)

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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ID#_____
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Daily Report Card	Study ID Number
Participant: First Name_____ Last Name_____	Date ☐☐ Month ☐☐ Year ☐☐☐☐

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)	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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26-01-18 - 26-01-19
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ID#_____
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Comprehensive report card

Participant:
First Name_____
Last Name_____

Study ID number

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?		
8. Were you hospitalized during the night?		
9. Was a stool sample taken?		
a. What were the results of the analysis?		
10. Did you take any medication for the symptoms?		
a. ☐ over the counter ☐ 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		
b. Total days of school missed due to symptoms		

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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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_____