

Follow-up Questionnaire for Asymptomatic Passengers and Crew, MERS CoV Aircraft Contact Investigation

Identifying and Residency Information (complete from 1st questionnaire)

Passenger's name: _____

Home Phone: _____ Mobile Phone: _____

E-mail address: _____

Flight Information: Date: ___/___/14 Destination: _____

Attempt(s) to reach passenger

Date	Time	Outcome (circle one)	Message left/e-mail sent
		Interview completed / not completed	
		Interview completed / not completed	
		Interview completed / not completed	
		Interview completed / not completed	
		Interview completed / not completed	

Name of person answering the questions (if not traveler): _____

Relationship of person answering questions (if not traveler): _____

Name of Interviewer: _____ Date of interview: (___/___/14)

Agency/Affiliation of Interviewer: _____

Follow-up for asymptomatic contacts [should be 14 days since the flight and will likely be less than 14 days from the date initially interviewed]

Script:

Thank you for agreeing to this follow-up call from (circle one): CDC/Health Department.

We are calling you to find out if you have become sick since our last conversation and if you saw a doctor.

Are you willing to answer a few questions? YES NO

If NO, thank the person for their time.

 You flew on ___/___/14. Fourteen days after this time period is [today's date or state other date]. This 14-day period is the monitoring period.

A. Illness History

1. Have you been ill since we last spoke with you? Yes No

IF YES, go to question #2. IF NO, thank the person for their time.

2. Have you had any of the following symptoms?

Specify date of onset in mm/dd/yy format for each Yes answer.

- a. **Fever (measured temp of > 100.4°F (38°C))** Yes (____°) Temp if known No
 Don't Know
- b. **Coughing** Yes No Don't Know
- c. **Difficulty breathing or shortness of breath** Yes No Don't Know
- d. **Wheezing** Yes No Don't Know
- e. **Pain with coughing or breathing** Yes No Don't Know
- f. Other symptom(s): Yes List _____ No Don't Know

If NO to 2. a-e, END.

3. What date did you first become ill with these symptoms? Date ___/___/14

4. Are you still sick? Yes No

4a. If NO, when did you feel better? Date ___/___/14

5. Did you see a doctor for this illness? Yes No

If YES,

- a. What date were you seen? Date ___/___/14
- b. Did you receive any treatment for the illness? Yes No
 i. If YES, specify: _____
- c. Were you tested by a medical provider for the illness (including, but not limited to, providing a blood sample or nasal or throat swab) since the day of your flight [insert date of flight]? Yes No
 i. If YES – Specify test or what kind of specimen was tested for you (e.g., blood, nasal swab, throat swab): _____
 1. Date (mm/dd/yy) ___/___/14

2. Facility where tested _____

- d. Were you admitted to the hospital (kept overnight, not just in emergency room)?
- Yes No If yes, which hospital? _____

6. Do you have any medical conditions that you are treated for regularly?

- Yes (Specify: _____) No Don't Know

7. For women: Are you currently pregnant? Yes No Don't Know**B. GEOGRAPHIC EXPOSURES**8. Have you visited the Middle East since [insert date **that is 14 days before** the flight date]*?

- Yes No **If NO, skip to Question 27.**

a. If YES : Dates of visit (mm/dd/yy) ___/___/14 to ___/___/14

b. List country(ies): _____

c. (Omit for crew) What was the purpose of your trip? (check all that apply)

- Visit family/friends Personal travel Business Study Other; specify: _____

9. While you were in the Middle East, did you:

a. Have any close contact with someone who was sick with the MERS coronavirus? Yes Nob. Have any close contact with someone who was sick with a serious respiratory infection, such as pneumonia? Yes Nob. Visit a health care facility? Yes Noc. (Omit for crew) Work in a health care facility? Yes No**Household Contacts**

10. Has anyone in your household or someone else you have had close contact with had fever, cough, difficulty breathing (or symptoms similar to what you described)?

- Yes *** No Don't Know

1. Name: _____

Relationship: _____

Symptoms: _____

Date of onset (mm/dd/yy): ____/____/____

Address: _____

Phone #: _____

2. Name: _____

Relationship: _____

Symptoms: _____

Date of onset (mm/dd/yy): ____/____/____

Address: _____

Phone #: _____

*** Note this person's name and contact information on the form for follow-up by local health department.

IF FEVER PLUS ANY RESPIRATORY SYMPTOMS (2 b-e).

- If ill person has not received health care, read symptomatic contact script.
- Send completed questionnaire to the health department.

CONSULT MEDICAL OFFICER IF FEVER ALONE OR WITH ONLY "OTHER" SYMPTOMS, OR RESPIRATORY SYMPTOMS WITHOUT FEVER.

THE END

Script: Thank you for taking the time to answer these questions.
Do you have any questions for me?