**Undetermined agent, source, mode of transmission, and risk factors for Guillain-Barré Syndrome in the setting of Zika virus transmission— Colombia, 2016**

**Case Control Investigation Questionnaire**

Investigation ID Number COL- \_\_\_\_ \_\_\_\_ - \_\_\_\_ □ Case □ Control

*The ID number begins with the 2 digit case number (for example COL01) followed by an “A” for the case patient, a “B” for the first control, a “C” for the second control, and a”D” for the third control. For example, the second control subject matched for case number 8 would be labeled “COL-08-C.”*

Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Interview: \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_ DD MM YYYY

Neuro Symptom Onset Date for Case \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_ DD MM YYYY

***The following questions are to be asked of cases AND controls during the interview:***

1. Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

(Street) (Town) (Province) (District)

2. Onset Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

(*for cases only if different from above; where cases spent most nights in the 2 months prior to neuro onset*)

3. GPS Coordinates (Onset for cases; current for controls): \_\_ \_\_. \_\_ \_\_ \_\_ \_\_ \_\_ S, \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_ \_\_ E

4. Sex: □ Male □ Female

5. Race: □ White □ Brown □ Indigenous □ Black/African decent □ Yellow □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Age when cases developed first neuro symptoms (or equivalent date for controls): \_\_\_\_\_\_ Years

7. What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you ever been told by a clinician that you have any of the following medical conditions?

□ Diabetes □ High blood pressure □ Heart disease □ High colesterol

□ Stroke □ Kidney disease □ Liver disease □ Rheumatologic disease

□ Asthma □ COPD □ Cancer □ Surgery (within 2 months of

symptom onset)

□ Other neurologic illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Take any medication or have any condition that might impact your ability to fight infections (e.g. prednisone):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. a. In the 2 months prior to \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_ (neuro onset date for case), have YOU been sick at all?

□ Yes □No □ Unknown

b. If so, when did you first feel sick? \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

c. If so, what symptoms did you have (check all that apply)?

□ Fevers □ Chills □ Nausea or Vomiting □ Diarrhea □ Muscle pains □ Joint pains □ Skin rash □ Abnormally red eyes

□ Headache □ Pain behind eyes □ Stiff neck □ Confusion

□ Abdominal pain □ Coughing □ Runny nose □ Sore throat □ Calf pain

□ Pruritus

d. If so, did you see a doctor or go to the hospital for this illness?

□ Yes □ No □ Unknown

Which doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. If so, did they draw any blood for testing? □ Yes □ No □ Unknown

10. a. In the 2 months prior to \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_ (neuro onset date for case), has anyone in your HOUSEHOLD been sick at all?

□ Yes □ No □ Unknown

b. If so, when did the first household member become sick? \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

c. If so, what symptoms did any household members have (check all that apply)?

□ Fevers □ Chills □ Nausea or Vomiting □ Diarrhea □ Muscle pains □ Joint pains □ Skin rash □ Abnormally red eyes

□ Headache □ Pain behind eyes □ Stiff neck □ Confusion

□ Abdominal pain □ Coughing □ Runny nose □ Sore throat □ Calf pain

□ Pruritus

11. Which vaccinations have you received and when?

□ Information verified on vaccine card □ Information provided verbally

Vaccine Number of doses Date of final dose

a. Hep B \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

b. HPV \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

c. Yellow fever \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

d. MMR \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

e. DT \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

f. DtaP \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

g. Influenza \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

h. Other vaccines (e.g. rabies, 23-pneumo, Japanese encephalitis, etc.):

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_

12. Since October 2015, what pets, farm, or other animals have lived in your house or on your property (check all that apply)?

□ Dogs □ Cats □ Mice/rats □ Pet birds □ Pet lizards /turtles

□ Goats □ Sheep □ Cows □ Chickens □ Pigs □ Other \_\_\_\_\_\_\_\_\_\_\_\_

13. Since October 2015, how often have you gotten your drinking water from the tap?

□Almost always (>75%) □Often (25-75%) □Rarely (<25%) □Never (0%)

If ever, was the water boiled or treated? □Yes □No □Unknown

14. Since October 2015, how often have you gotten your drinking water from a well or river/stream/pond?

□Almost always (>75%) □Often (25-75%) □Rarely (<25%) □Never (0%)

If ever, was the water boiled or treated? □Yes □No □Unknown

15. In 2015, how often do you walk around barefoot outside?

□Almost always (>75%) □Often (25-75%) □Rarely (<25%) □Never (0%)

16. In 2015, have you swam or waded in a freshwater river, stream, or pond?

□Daily □Weekly □Monthly □Rarely (<once per month) □Never

17. In 2015, do you recall being bitten by a mosquito? □Yes □No □Unknown

18. How much time do you spend outdoors each day?

□<1 hour □1-4 hours □5-8 hours □>8 hours

19. Do you normally wear insect repellant?

□Almost always (>75%) □Often (25-75%) □Rarely (<25%) □Never (0%)

20. Do you leave the windows open at your house?

□Yes, during the day □Yes, at night □Yes, all times □Windows are not left open at this house

21. How many of your windows or doors have intact screens?

□All of them □Some of them □None of them

22. Does your home use any of the following for air conditioning (check all that apply)?

□Local air conditioning (at least 1 room) □Fans □None

23. How often do you have sources of standing water around the outside of your house (e.g. buckets, water storage/cistern, septic tank, pond)?

□Daily □2-3 times/week □Once/week □Every other week □Never

24. Since October 2015, have you slaughtered any animals? □Yes □No □Unknown

Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

25. Since October 2015, have you handled any dead animals? □Yes □No □Unknown

Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_

26. In 2016, have you eaten or drunk any of the following foods at least once per week (check all that apply)?

□ Beef □ Lamb □ Chicken □ Fish □ Shellfish

□ Milk □ Cheese □ Yogurt □ Fresh salad / uncooked greens

27. In 2016, did you eat any of the following foods raw or undercooked (check all that apply)?

□ Beef □ Lamb □ Chicken □ Fish □ Shellfish

28. Hughes Disability Score: (Date recorded \_\_ \_\_ /\_\_ \_\_ /\_\_ \_\_)

Hughes Disability Score (0 to 6): \_\_\_\_\_\_\_ □ Unknown

*[0 = Complete recovery; no sequelae, 1 = Minor symptoms and capable of running, 2 = Able to walk 10 metres or more without assistance but unable to run, 3 = Able to walk 10 metres with help, 4 = Bedridden or chairbound (unable to walk 10 meters with help), 5 = Requiring assisted ventilation for at least part of the day, 6 = Dead]*