|  |
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| **Section 1: Interviewer information** *(Questions 1-5 to be completed by interviewer prior to questionnaire administration)* |
| 1. Subject ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | 1. Inmate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 1. Date of Interview:
 |  \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ *(if unknown, enter 99/99/9999)* *M M D D Y Y Y Y* |
| 1. Interviewer Information Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Agency or Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Location of interview:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |
| 1. Respondent was:
 | [ ] Self [ ] Family [ ] Clinician [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Respondent is:
 | [ ] Confirmed case [ ] Suspected case [ ] Not a case [ ] Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**QUESTIONNAIRE FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*, JUNE 2016**

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| **Section 2: Demographic Data:**  |
| 1. Birth month and year
 |  \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ *(if unknown, enter 99/9999)* *M M Y Y Y Y* |
| 1. Sex: [ ]  Male [ ]  Female [ ]  Unknown
 |
| 1. Hispanic or Latino origin? [ ]  Yes [ ]  No [ ]  Unknown
 |
| 1. How would you describe your race?
 | [ ]  White [ ]  Black/ African American [ ]  American Indian/Alaska Native [ ]  Asian[ ]  Native Hawaiian/Other Pacific Islander [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown |
| 1. What is your cell/ward location in the prison:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 1. What are your prison duties or job (kitchen staff, lawn crew, janitorial):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

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| **Section 3: Food allergies, special diets:**  |
| **Yes** | **Maybe** | **No** | **Don’t Know** | Did you have: |
| [ ]  | [ ]  | [ ]  | [ ]  | 1. Any allergies that prevent you from eating a certain food(s)?
 |
|  |  1a. What foods?  *Please check all that apply*. | [ ]  Milk [ ]  Eggs [ ]  Peanuts [ ]  Tree nuts [ ]  Fish [ ]  Soy [ ]  Wheat [ ]  Shellfish [ ]  other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | [ ]  | 1. Do you follow any of the following special or restricted diets?
 |
|  |  [ ]  Dairy‐free [ ]  Vegetarian/Vegan [ ]  Kosher  [ ]  Gluten‐free [ ]  Other religious diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Section 4 Comments.** *Please fill in any comments/notes from this section in the space provided below:* |

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| **Section 4: Sources of food:**  |
| 1. In the past two week, did you eat foods from?

|  |  |
| --- | --- |
| [ ]  Prison cafeteria | [ ]  Food brought to you in the prison by friend or relatives |
| [ ]  Food prepared in cell | [ ]  Food shared from other prisoners |
| [ ]  Prison shop | [ ]  Food bought or traded from other prisoners |
| [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

 |

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| 1. **In the past two weeks have you stored food in your cell?**

[ ]  Yes [ ]  No 1. **In the past two weeks have you consumed food prepared in your cell?**

[ ]  Yes [ ]  No  |

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| **Section 5: Food items:** |
| 1. Did you eat any of the follow food items served in the prison cafeteria?:

\*\*\* To be completed with prison food menu. |
| Food item | Yes | No | Don’t know | Unknown |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Have you eaten any additional food items in the past two weeks?: |
| **Section 4 Comments.** *Please fill in any comments/notes from this section in the space provided below:* |

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| **Section 6: Hooch:** Now I have a few questions about Hooch or Pruno.  |
| **Yes** | **Maybe** | **No** | **Don’t Know** |  |
| [ ]  | [ ]  | [ ]  | [ ]  | 1. Have you ever drank hooch since you entered the prison?
 |
|  |  |  |  | 1a. How often do you drink hooch? [ ]  daily [ ]  weekly [ ]  monthly [ ]  less than monthly [ ]  when it is available [ ]  don’t know |
| [ ]  | [ ]  | [ ]  | [ ]  | 1. Have you drank hooch since June 1st?
 |
|  |  2a. How many times did you drink hooch since June 1st? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2b. When did you first drink the hooch? \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_  2c. On average, how much hooch did you drink each time?  [ ]  a sip [ ]  a cup [ ]  a pint [ ]  more than a pint [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2d. Did you share with other people? [ ]  Yes [ ]  No [ ]  Don’t know How many people did you share with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are any of these people currently sick?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2e. Do you still have hooch in your cell? [ ]  Yes [ ]  No [ ]  Don’t know 2f. Where did you get the hooch?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2g. Do you know when the batch of hooch that you made was dug up or first drank? [ ]  Yes [ ]  No [ ]  Don’t know If yes, when? \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_  |
| **Section 4 Comments.** *Please fill in any comments/notes from this section in the space provided below:* |

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| **Section 7: Clinical Information:**.  |
| 1. What date did you first feel sick?
 |  \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ *(if unknown, enter 99/99/9999)* [ ]  Not sick *M M D D Y Y Y Y* |
| 1. How many days total were you sick?
 | \_\_\_\_\_\_\_ days *(enter 999 if unknown)* or [ ]  Still Ill |
| **Yes** | **No** | **Don’t Know** | Was the patient:  |
| [ ]  | [ ]  | [ ]  | 1. Hospitalized overnight?
 |
|  |  |  |  Date of hospitalization \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ |
|  |  |  |  Date of discharged \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ or [ ]  Still hospitalized |
|  |  |  |  Admitted to ICU? [ ]  Yes [ ]  No [ ]  Don’t know |
| [ ]  | [ ]  | [ ]  | 1. Intubated?
 |
|  |  |  |  Date of intubation \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ |
|  |  |  |  Date stopped intubation \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ or [ ]  Still Intubation |
| [ ]  | [ ]  | [ ]  | 1. Did patient receive HBAT
 |
|  |  |  |  Date of HBAT administration \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ |
| **Did the patient have any of the following symptoms:** |
| **Yes** | **No** | **Don’t Know** | Symptom |
| [ ]  | [ ]  | [ ]  | Change in sound of voice |
| [ ]  | [ ]  | [ ]  | Abdominal Pain |
| [ ]  | [ ]  | [ ]  | Hoarseness |
| [ ]  | [ ]  | [ ]  | Diarrhea |
| [ ]  | [ ]  | [ ]  | Dry mouth |
| [ ]  | [ ]  | [ ]  | Constipation |
| [ ]  | [ ]  | [ ]  | Dysphagia (difficulty swallowing) |
| [ ]  | [ ]  | [ ]  | Blurred Vision |
| [ ]  | [ ]  | [ ]  | Shortness of breath |
| [ ]  | [ ]  | [ ]  | Diplopia (double vision) |
| [ ]  | [ ]  | [ ]  | Subjective weakness |
| [ ]  | [ ]  | [ ]  | Dizziness |
| [ ]  | [ ]  | [ ]  | Fatigue |
| [ ]  | [ ]  | [ ]  | Slurred Speech |
| [ ]  | [ ]  | [ ]  | Paresthesia (abnormal sensation, e.g. numbness) |
| [ ]  | [ ]  | [ ]  | Thick tongue |
| [ ]  | [ ]  | [ ]  | Nausea |
| [ ]  | [ ]  | [ ]  | Extraocular Palsy (paralysis of eye muscles) |
|  |  If yes, is it bilateral? |
|  If bilateral, is it symmetric? |
| [ ]  | [ ]  | [ ]  | Ptosis (drooping eyelids) |
| [ ]  | [ ]  | [ ]  | Facial Paralysis |
|  |  If yes, is it bilateral? |
|  If bilateral, is it symmetric? |
| [ ]  | [ ]  | [ ]  | Palatal weakness |
|  |  If yes, is it bilateral? |
| [ ]  | [ ]  | [ ]  | Impaired gag reflex |
| [ ]  | [ ]  | [ ]  | Other sensory deficit(s) |
|  | Which ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  | [ ]  | [ ]  | Other symptoms? |
|  |  |  | Which ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Clinical history:** |
| **Yes** | **No** | **Don’t Know** | Comorbidity |
| [ ]  | [ ]  | [ ]  | HIV |
| [ ]  | [ ]  | [ ]  | TB |
| [ ]  | [ ]  | [ ]  | Hepatitis C |
| [ ]  | [ ]  | [ ]  | Hypertension |
| [ ]  | [ ]  | [ ]  | Diabetes |
| [ ]  | [ ]  | [ ]  | Other Comorbidity(ies)? |
|  | Which other(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |