

Section 1: INTERVIEWER INFORMATION (Questions 1-5 to be completed by interviewer prior to questionnaire administration)

1. Subject ID: _____ 2. Inmate #: _____

3. Date of Interview: _____ / _____ / _____ (if unknown, enter 99/99/9999)
 M M / D D / Y Y Y Y

4. Interviewer Information Name: _____
 Agency or Organization: _____

5. Location of interview: _____

6. Respondent was: Self Family Clinician Other (Specify): _____

7. Respondent is: Confirmed case Suspected case Not a case Other (Specify): _____

QUESTIONNAIRE FOR PRISON OUTBREAK OF CLOSTRIDIUM BOTULINUM, JUNE 2016

Section 2: DEMOGRAPHIC DATA:

1. Birth month and year _____ / _____ (if unknown, enter 99/9999)
 M M / Y Y Y Y

2. Sex: Male Female Unknown

3. Hispanic or Latino origin? Yes No Unknown

4. How would you describe your race? White Black/ African American American Indian/Alaska Native Asian
 Native Hawaiian/Other Pacific Islander Other (specify): _____ Unknown

5. What is your cell/ward location in the prison: _____

6. What are your prison duties or job (kitchen staff, lawn crew, janitorial): _____

Section 3: FOOD ALLERGIES, SPECIAL DIETS:

Yes	Maybe	No	Don't Know	Did you have:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Any allergies that prevent you from eating a certain food(s)?
				1a. What foods? <input type="checkbox"/> Milk <input type="checkbox"/> Eggs <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nuts <input type="checkbox"/> Fish Please check all that apply. <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Shellfish <input type="checkbox"/> other: _____
				2. Do you follow any of the following special or restricted diets? <input type="checkbox"/> Dairy-free <input type="checkbox"/> Vegetarian/Vegan <input type="checkbox"/> Kosher <input type="checkbox"/> Gluten-free <input type="checkbox"/> Other religious diet: _____ <input type="checkbox"/> Other: _____

Section 4 Comments. Please fill in any comments/notes from this section in the space provided below:

Section 4: SOURCES OF FOOD:

1. In the past two week, did you eat foods from?

<input type="checkbox"/> Prison cafeteria	<input type="checkbox"/> Food brought to you in the prison by friend or relatives
<input type="checkbox"/> Food prepared in cell	<input type="checkbox"/> Food shared from other prisoners
<input type="checkbox"/> Prison shop	<input type="checkbox"/> Food bought or traded from other prisoners
<input type="checkbox"/> Other: _____	

2.

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

Yes No

4. **In the past two weeks have you consumed food prepared in your cell?**

Yes No

Section 5: FOOD ITEMS:

5. 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:

Section 6: HOOCH: Now I have a few questions about Hooch or Pruno.

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever drank hooch since you entered the prison?
				1a. How often do you drink hooch? <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> less than monthly <input type="checkbox"/> when it is available <input type="checkbox"/> don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. 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? <input type="checkbox"/> a sip <input type="checkbox"/> a cup <input type="checkbox"/> a pint <input type="checkbox"/> more than a pint <input type="checkbox"/> Other: _____
				2d. Did you share with other people? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If yes, when? ___ / ___ / _____

Section 4 Comments. Please fill in any comments/notes from this section in the space provided below:

Section 7: CLINICAL INFORMATION:

1. What date did you first feel sick? / / (if unknown, enter 99/99/9999) Not sick

2. How many days total were you sick? days (enter 999 if unknown) or Still Ill

Yes	No	Don't Know	Was the patient:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Hospitalized overnight? Date of hospitalization <u> </u> / <u> </u> / <u> </u> Date of discharged <u> </u> / <u> </u> / <u> </u> or <input type="checkbox"/> Still hospitalized Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Intubated? Date of intubation <u> </u> / <u> </u> / <u> </u> Date stopped intubation <u> </u> / <u> </u> / <u> </u> or <input type="checkbox"/> Still Intubation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Did patient receive HBAT Date of HBAT administration <u> </u> / <u> </u> / <u> </u>

Did the patient have any of the following symptoms:

Yes	No	Don't Know	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in sound of voice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dysphagia (difficulty swallowing)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diplopia (double vision)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Subjective weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slurred Speech
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paresthesia (abnormal sensation, e.g. numbness)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thick tongue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extraocular Palsy (paralysis of eye muscles) If yes, is it bilateral? If bilateral, is it symmetric?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ptosis (drooping eyelids)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facial Paralysis If yes, is it bilateral? If bilateral, is it symmetric?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palatal weakness

			If yes, is it bilateral?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired gag reflex
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other sensory deficit(s)
			Which ones? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms?
			Which ones? _____
Clinical history:			
Yes	No	Don't Know	Comorbidity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Comorbidity(ies)?
			Which other(s)? _____