Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Undetermined source for Salmonella Infantis infections among detention center inmates — South Carolina, 2016

CASE INTERVIEW FORM

CDC ID: ☐☐☐☐ **Date:** ☐☐/☐☐/☐☐ **Data collector initials:** _____

1. Last Name_____ First Name_____

2. **Unit:**

3. **DOB:** ☐☐/☐☐/☐☐☐☐

4. **When was the first documented episode of diarrhea:** ☐☐/☐☐/☐☐☐☐

Foodborne disease outbreak questionnaire (Prison A) Interviewer name: _____

INTERVIEWER INFORMATION *(Questions 1-4 to be completed by interviewer prior to questionnaire administration)*

1. PulseNet ID #: _____ **(Required)**

2. State/Local/Other ID #: _____

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

4. Interviewer Information Contact phone number: **(___) _____-_____**
Agency or Organization: _____

5. Stool sample: Yes/No Result: _____

Part I. Demographics:

6. Age: _____
Sex_____(M/F)

7. Race (check all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian/other Pacific Islander
- ☐ Unknown
- ☐ Other race

8. Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

9. Unit: _____ Cell#: _____Bed#_____ In Isolation: Yes / No

10. When were you admitted to this detention center? Date: ____ / ____ / ____

11. What work do you perform at this detention center? _____

12. Where do you perform this work? _____

13. Do you help in the kitchen or handle food? Yes / No

Part II. Clinical information

1. Have you had any symptoms of gastrointestinal illness during the week of July 10th, 2016? Yes / No
2. What day did your symptoms begin: _____ / ____ / ____ / ____ (example: Tuesday MM/DD/YY)
3. *Please circle when you began feeling sick:*

1 AM	7 AM	1 PM	7 PM
2	8	2	8
3	9	3	9
4	10	4	10
5	11	5	11
6 AM	12 Noon	6 PM	12 Midnight

4. Did you have any of the following symptoms during the week of July 10th, 2016?:

Symptom	Yes/No/Unknown	Onset Date	Notes
Nausea	☐Yes ☐No ☐Unk	___/____/_____	
Vomiting	☐Yes ☐No ☐Unk	___/____/_____	If yes, what is the largest number of episodes you had in a 24 hour period ? _____
Diarrhea	☐Yes ☐No ☐Unk	___/____/_____	
Bloody Diarrhea	☐Yes ☐No ☐Unk	___/____/_____	If yes, what is the largest number of episodes you had in a 24 hour period ? _____ Did you provide a stool sample? ☐Yes ☐No
Fever	☐Yes ☐No ☐Unk	___/____/_____	Highest temperature, if measured _____☐°C or ☐°F
Chills	☐Yes ☐No ☐Unk	___/____/_____	
Headache	☐Yes ☐No ☐Unk	___/____/_____	
Abdominal pain/cramping	☐Yes ☐No ☐Unk	___/____/_____	
Body aches	☐Yes ☐No ☐Unk	___/____/_____	
Fatigue/Tiredness	☐Yes ☐No ☐Unk	___/____/_____	
Dizziness	☐Yes ☐No ☐Unk	___/____/_____	
Other:_____ _____	xYes	___/____/_____	

5. Have your symptoms stopped? Yes / No
6. If yes, when did your symptoms end? Date____ / ____ / ____
7. Did you seek medical care at the infirmary or go to sick call? Yes / No
   a. When? Date____ / ____ / ____ Time____:____ AM/ PM
8. Did you receive intravenous (IV) fluids? Yes / No
9. Did you receive any medications? Yes / No 9a) If yes, specify: _____
10. Were you hospitalized for this illness? Yes / No
11. When were you admitted to the hospital? Date____ / ____ / ____

12. When did you return from the hospital? Date____ / ____ / ____

Part III. Food:

	Did you eat in the cafeteria on this day?	Did you eat an alternate meal?
Saturday, July 9	Yes No	Yes No If yes, describe: _____ _____ _____ _____
Sunday, July 10	Yes No	Yes No If yes, describe: _____ _____ _____ _____
Monday, July 11	Yes No	Yes No If yes, describe: _____ _____ _____ _____
Tuesday, July 12	Yes No	Yes No If yes, describe: _____ _____ _____ _____ _____
Wednesday, July 13	Yes No	Yes No If yes, describe: _____ _____ _____ _____ _____

Please place an X next to any food item you ate on any of these days:

Saturday, July 9		Sunday, July 10		Monday, July 11		Tuesday, July 12		Wednesday, July 13	
Breakfast		**Breakfast**		**Breakfast**		**Breakfast**		**Breakfast**	
				Grits		Fruit Drink		Oatmeal	
				Biscuit		Oatmeal		Breakfast sausage	
				Sausage		Scrambled Eggs		Pancake square	
				Gravy		O'Brien potatoes		Margarine	
				Lyonnaise Potatoes		Biscuit		Maple syrup	
				Margarine		Margarine		Dairy Drink	
				Dairy Drink		Jelly		Cornbread	
						Dairy Drink			
Lunch		**Lunch**		**Lunch**		**Lunch**		**Lunch**	
				Turkey Bologna		Cheese Slice		Ham?	
				Creamy Cole Slaw		Turkey Salami		Italian Pasta Salad	
				Bread		Marinated Vegetable Salad		Bread	
				Mustard		Bread		Mustard	
				Cookie Square		Mustard		Cookie Square	
				Fruit Drink		Cookie Square		Fruit Drink	
						Fruit Drink			
Dinner		**Dinner**		**Dinner**		**Dinner**		**Dinner**	
				Italian Meat Sauce		Chili Con Carne		Meatloaf	
				Spaghetti Noodles		Plain rice		?	
				Seasoned Green Beans		Seasoned Cabbage		Fluffy Rice	
				Garlic Bread		Cornbread		Mixed Beans	
				?		Margarine		Cornbread	
				Sweat tea		?		?	
						Sweet Tea		Frosted Chocolate Cake	
								Sweet tea	

Now, I will ask you more questions about what you ate and drank during the week of July 10th. Try to remember and answer as best as you can.

Please circle or specify any other food-related items that you ate:
ice spread mayonnaise other condiments
Other specify: _____
Was any of the food you ate undercooked? Yes / No / DK
If yes, Specify: _____

Did you eat any food not provided by the cafeteria? Yes / No
Specify: _____

If yes, where was that food obtained?
Specify: _____

Did you drink any beverages not provided by the cafeteria? Yes / No
Specify: _____

If yes, where was that drink obtained?
If yes, Specify: _____

Did you eat any leftover food from previous days? Yes / No
If yes, Specify: _____

If yes, do you remember when you obtained that food? _____/_____ (MM/DD)

Did you prepare any food in your barracks (e.g. "spread")? **Yes / No**
If yes, specify:_____

Did you eat the food that you prepared in your barracks? Yes / No
Date of preparation ____/_____ (MM/DD)
Date of consumption ____/_____ (MM/DD)

Did you share the food that you prepared in your barracks with anyone else? Yes / No
If yes, specify: _____

Do you have any food allergies? **Yes/No**
If yes, specify: _____

Are there any foods that you do not eat? **Yes/No**
If yes, specify: _____

What time do you typically eat? Breakfast _____AM Lunch _____AM / PM Dinner: _____ PM
Other_____

Part IV. Handwashing Practices

How many times per day do you usually wash your hands? _____

Describe the times of day when you wash your hands. _____
_____
_____

Part V. Medical History:

Do you have any of the following conditions? *(check all that apply)* ☐ None ☐ Unknown

- ☐ Asplenia
- ☐ Autoimmune disease
- ☐ Cancer, any (incl. leukemia/lymphoma)
- ☐ Chronic kidney disease (with or without dialysis)
- ☐ Chronic liver disease (incl. cirrhosis)
- ☐ Chronic pulmonary disease (incl. COPD/emphysema, asthma)
- ☐ Congestive heart failure
- ☐ Connective tissue disease
- ☐ Diabetes mellitus
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ HIV/AIDS
- ☐ Ischemic heart disease/Myocardial infarction/Peripheral vascular dz
- ☐ IV drug use in past year
- ☐ Peptic ulcer disease
- ☐ Pregnancy (current)
- ☐ Prosthetic device or vascular graft
- ☐ Recurrent cystitis or urinary tract infection
- ☐ Sickle cell disease
- ☐ Smoking in past year
- ☐ Transplant (incl. solid organ, hematopoietic stem cell, bone marrow)
- ☐ Other _____

Part VI. Notes: *(Add any comments not specifically asked on questionnaire)*

_____

_____

_____

_____

_____

_____

_____

_____