Team #: \_\_\_\_\_\_\_ Interviewer: \_\_\_\_\_\_\_\_\_ Date of interview (MM/DD/YYYY): \_\_\_/\_\_\_/\_\_\_\_

Individual ID (e.g., S-1-A-1): \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First (given) Initial Paternal Maternal

2. Sex: **□** Male **□**Female **□**Other **□**Refuse to answer

3. Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

4. For females only: Are you currently pregnant (circle one) **□**Yes **□**No

4a. If yes, please provide name and contact information of your obstetrician (or general physician if you do not have an obstetrician yet).

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. How long have you been living in Puerto Rico? \_\_\_\_\_\_\_ years **□** Refuse to answer

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

**□** Diabetes **□** High blood pressure **□** Heart disease **□** High cholesterol

**□** Stroke **□** Kidney disease **□** Liver disease **□** Thyroid disease

**□** Asthma **□** Lung disease **□** Joint disease/arthritis **□** Cancer

**□** Lupus **□** Other autoimmune disease (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**□** None of the above

**□** Refuse to answer / Don’t know

7. Do you take any of the following medications daily:

**□** NSAID (e.g., aspirin, Ibupofen) **□** Corticosteroids **□** Antibiotics

**□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** None

**□** Refuse to answer / Don’t know

8. Have you had any new, acute illnesses in the past 6 months?

*Note to interviewer: this should not include flare-ups of chronic illnesses.*

**□**Yes **□**No **□** Refuse to answer / Don’t recall

*(If more than one illness episode, use additional copy of questions 8 – 8d-3 to record, and document each additional episode in Notes.)*

8a. If yes, first day of illness (MM/DD/YYYY): \_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note to interviewer: ask for best guess of participant, even if they can remember only the week. Show calendar to participant to aid recall.*

**□** Refuse to answer / Don’t recall

8b. What symptoms did you have (check all that apply)?

**□** Fever **□** Skin rash **□** Nausea/Vomiting **□** Diarrhea

**□** Muscle pain **□** Joint pain **□** Chills **□** Red eyes

**□** Headache **□** Pain behind eyes **□** Abdominal pain **□** Cough

**□** Runny nose **□** Sore throat **□** Calf pain **□** Arthritis (red, swollen joints)

**□** Minor bleeding (e.g., petechiae, gum bleeding, nosebleeds, bruising)

**□** Major bleeding (e.g., vomiting blood, coughing up blood, blood in stool, heavy menses)

**□** Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Don’t recall /Refuse to answer

8c. How long did this illness last? \_\_\_\_\_\_ days **□** Don’t recall /Refuse to answer

8d. Did you go to the doctor because of this illness? **□** Yes **□** No

□ Don’t recall / Refuse to answer

8d-1. If yes, how many times did you seek medical attention for this illness?

\_\_ times **□** I don’t know **□** Refuse to answer / Don’t recall

8d-2. What was the diagnosis? **□**Zika **□**Chikungunya **□** Dengue

**□** Viral syndrome, unspecified **□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Refuse to answer / Don’t know

8d-3. Were you hospitalized for this illness? **□** Yes **□** No

**□** Refuse to answer / don’t recall

8d-4a. If yes, Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8d-4b. Days in the hospital: \_\_\_\_\_ days

**□** I don’t know **□** Refuse to answer

9. During an average week from 7am–7pm, many hours are you at home or in this community on (maximum = 12)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|  |  |  |  |  |  |  |

**□** Refuse to answer / Don’t know

*Note to interviewer: ask the participant for their best guess.*

10. How frequently do mosquitoes bite you? **□** Daily **□** At least once a week **□** Rarely

**□** Never **□** Don’t know / Refuse to answer

11. When do mosquitoes usually bite you? (*select all that apply*) **□** Morning **□** Daytime **□** Evening **□** Night-time **□**Mosquitoes don’t bite me **□** Refuse to answer / don’t know

12. Where do mosquitoes usually bite you? (*select all that apply*) **□** Home **□** Work/school **□** Others’ homes inside my community **□** Others’ homes outside my community

**□** Elsewhere **□** Mosquitoes don’t bite me **□** Refuse to answer / don’t know

13. Have you used mosquito repellent in the past month?

**□** Daily **□** Weekly **□** Never **□** Refuse to answer / don’t know

14. Have you slept under a bednet in the past month? **□** Yes **□** No

**□** Refuse to answer / don’t recall

15. What is the highest level of education that you have completed?

**□** No school **□** Grades 1 through 8 **□** Grades 9 through 11 **□** Grade 12 or GED

**□** Some college, Associate’s, or Technical Degree **□** Bachelor’s Degree

**□** Any post graduate studies

**□** Do not know / Refused to answer

**NOTES**: