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

MEDICAL CHART ABSTRCTION FORM

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Fungal Bloodstream Infections Related to Oncology Practice A – Chart Abstraction Form

CDCID:_____ **Clinic Chart #:** _____

1. **Past Medical History**
   Underlying diseases **(**check all that apply**)**:
   X Cancer, type: _____
   ☐Diabetes mellitus ☐Alcohol dependence/heavy alcohol use
   ☐immunosuppressive condition i.e. HIV/AIDS
   ☐Other disease (list below) ☐Info not available

   If other, list: _____
   _____
   _____

2. **Clinic Visits**

Visit 1	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____
Visit 2	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____
Visit 3	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____

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Visit 4	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____

Visit 5	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____
Visit 6	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____
Visit 7	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types? ☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____
Vis it 8	**Visit Date:** ___/___/_____ (MM/DD/YYYY)
	Does the patient have any of the following access types?

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	☐Port-a-cath ☐PICC line ☐Central line ☐Hickman catheter ☐Implantable port ☐Other: _____ ☐Unknown ☐None ☐Peripheral IV
	Did the patient receive any of the following (check all that apply): ☐Heparin ☐Dexamethasone ☐Ondansetron ☐Aloxi ☐Chemo1:_____ ☐Chemo2:_____ ☐Chemo3:_____ ☐Flush1 ☐Flush2 ☐None ☐Other:_____

3. Microbiology

Culture	Date/Time	Specimen Site	Culture type	Result
1	____/____/____ ____:____	☐ Port ☐ PICC ☐ Peripheral ☐ Other_____ ☐ Unknown	☐ Aer/Anae ☐ Fungal	☐ No growth final ☐ Positive Organism 1_____ Organism 2_____ Organism 3_____
Culture	**Date/Time**	**Specimen Site**	**Culture type**	**Result**
2	____/____/____ ____:____	☐ Port ☐ PICC ☐ Peripheral ☐ Other_____ ☐ Unknown	☐ Aer/Anae ☐ Fungal	☐ No growth final ☐ Positive Organism 1_____ Organism 2_____ Organism 3_____
Culture	**Date/Time**	**Specimen Site**	**Culture type**	**Result**
3	____/____/____ ____:____	☐ Port ☐ PICC ☐ Peripheral ☐ Other_____ ☐ Unknown	☐ Aer/Anae ☐ Fungal	☐ No growth final ☐ Positive Organism 1_____ Organism 2_____ Organism 3_____
Culture	**Date/Time**	**Specimen Site**	**Culture type**	**Result**
4	____/____/____ ____:____	☐ Port ☐ PICC ☐ Peripheral ☐ Other_____ ☐ Unknown	☐ Aer/Anae ☐ Fungal	☐ No growth final ☐ Positive Organism 1_____ Organism 2_____ Organism 3_____
Culture	**Date/Time**	**Specimen Site**	**Culture type**	**Result**
5	____/____/____ ____:____	☐ Port ☐ PICC ☐ Peripheral ☐ Other_____ ☐ Unknown	☐ Aer/Anae ☐ Fungal	☐ No growth final ☐ Positive Organism 1_____ Organism 2_____ Organism 3_____
Culture	**Date/Time**	**Specimen Site**	**Culture type**	**Result**

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6	____/____/____ ____:____	☐ Port ☐ PICC ☐ Peripheral ☐ Other_____ ☐ Unknown	☐ Aer/Anae ☐ Fungal	☐ No growth final ☐ Positive Organism 1_____ Organism 2_____ Organism 3_____

4. Symptoms at time of culture

Did patient have any of the following symptoms at the time of culture?

Fever	☐Yes	☐No	☐UNK	_____
If yes, Temp: _____°F				
Malaise (feeling poorly)	☐Yes	☐No	☐UNK	_____
Headache	☐Yes	☐No	☐UNK	_____
Chills	☐Yes	☐No	☐UNK	_____
Arthralgias	☐Yes	☐No	☐UNK	_____
Chest pain	☐Yes	☐No	☐UNK	_____
Weakness	☐Yes	☐No	☐UNK	_____
Fatigue	☐Yes	☐No	☐UNK	_____
Lethargy	☐Yes	☐No	☐UNK	_____
Night Sweats	☐Yes	☐No	☐UNK	_____
Shortness of Breath	☐Yes	☐No	☐UNK	_____
Anorexia	☐Yes	☐No	☐UNK	_____
Muscle ache	☐Yes	☐No	☐UNK	_____
Rash	☐Yes	☐No	☐UNK	_____
If Yes, describe:_____				
Other symptoms	☐Yes	☐No	☐UNK	_____
If Yes, specify:_____				

5. Beta-D-glucan (if applicable)

Date performed	Specimen	Result
____/____/____	☐CSF ☐Blood	Level: _____
____/____/____		Level: _____
____/____/____		Level: _____

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____/____/____		Level: _____
____/____/____		Level: _____
____/____/____		Level: _____

6. Hospitalization Information

Admission Date: ____/____/____ (MM/DD/YY)

Discharge Date: ____/____/____ (MM/DD/YY)

Did patient have any of the following symptoms at time of admission?

Fever	☐Yes	☐No	☐UNK	_____
If yes, Temp: _____°F				
Malaise (feeling poorly)	☐Yes	☐No	☐UNK	_____
Headache	☐Yes	☐No	☐UNK	_____
Chills	☐Yes	☐No	☐UNK	_____
Arthralgias	☐Yes	☐No	☐UNK	_____
Chest pain	☐Yes	☐No	☐UNK	_____
Weakness	☐Yes	☐No	☐UNK	_____
Fatigue	☐Yes	☐No	☐UNK	_____
Lethargy	☐Yes	☐No	☐UNK	_____
Night Sweats	☐Yes	☐No	☐UNK	_____
Shortness of Breath	☐Yes	☐No	☐UNK	_____
Anorexia	☐Yes	☐No	☐UNK	_____
Muscle ache	☐Yes	☐No	☐UNK	_____
Rash	☐Yes	☐No	☐UNK	_____
If Yes, describe:_____				
Other symptoms	☐Yes	☐No	☐UNK	_____
If Yes, specify:_____				

Was port removed? ☐Yes ☐No ☐N/A (no port)

If Yes, date of port removal: ___/___/___

Results of port culture:_____

If No, reason port was not removed: _____

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Complete table for all antifungals and antibiotics received, if known: ☐Unknown

Antifungal/Antibiotic	Dose	Start Date	Stop Date

Admitted to:
☐MICU ☐General medicine ☐Other_____ ☐Unknown

Outcome:
☐Died ☐Survived

If deceased, date of death:
_____/_____/_____ (MM/DD/YY) ☐Unknown

If survived, date of discharge:
_____/_____/_____ (MM/DD/YY) ☐Unknown

Notes:

_____

_____

_____

_____

_____

Chart Review Completed by: _____

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CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016

Abstractor initials _____ Date _____ CDC # _____

CASE INFORMATION
Medical facility ☐ Correctional facility health services unit ☐ Hospital, name _____ Medical record # _____ Patient Age _____ Sex: ☐ Male ☐ Female Hispanic or Latino origin: ☐ Yes ☐ No ☐ Unknown Race: ☐ White ☐ Black/ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other (specify): _____ ☐ Unknown Height _____ in / cm Weight _____ lb / kg BMI _____
Notes:

PAST MEDICAL HISTORY	
Health condition	**Notes**
Notes:	

PAST SURGICAL HISTORY		
Procedure	**Date**	**Notes**
Notes:		

CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016

Abstractor initials _____ Date _____ CDC # _____

MEDICATIONS IN PAST 6 MONTHS (Prior to hospitalization)				
Name	**Frequency**	**Duration**	**Dose**	**Notes**
Notes:				

BEHAVIORAL HEALTH RISK FACTORS				
Behavior	**Yes**	**No**	**Prior**	**Notes (Type, frequency, etc.)**
Smoking	☐	☐	☐	
Other tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Recreational drug use	☐	☐	☐	
Injection drug use	☐	☐	☐	
Notes:				

EXPOSURE HISTORY
Reported consuming hooch or pruno: ☐ Yes ☐ No When _____
Amount _____ Color of hooch/pruno _____
Notes:

CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016

Abstractor initials _____ Date _____ CDC # _____

HOSPITAL ADMISSION

Presentation: Date _____ Time _____ Admitted: ☐ Yes ☐ No

Vital signs upon presentation:

Temperature _____ ˚C / ˚F Blood pressure _____ / _____ mmHg

Heart Rate _____ beats/ min Respiration Rate _____ breaths/min

Presenting symptoms _____

Onset Date _____ Time _____

Notes:

SYMPTOMS (ER and admission note, plus neuro consult)

Symptom	Yes	No	Unknown	Date / time first reported
Nausea	☐	☐	☐	
Vomiting	☐	☐	☐	
Diarrhea	☐	☐	☐	
Constipation	☐	☐	☐	
Abdominal Pain	☐	☐	☐	
Dry mouth	☐	☐	☐	
Hoarseness, or change in sound of voice	☐	☐	☐	
Slurred Speech	☐	☐	☐	
Difficulty swallowing	☐	☐	☐	
Thick tongue	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Blurred Vision	☐	☐	☐	
Double vision / diplopia	☐	☐	☐	
Dizziness	☐	☐	☐	
Weakness	☐	☐	☐	
Fatigue	☐	☐	☐	
Numbness or tingling	☐	☐	☐	
Urinary retention	☐	☐	☐	
Other:_____	☐	☐	☐	
Other:_____	☐	☐	☐	

Notes:

CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016

Abstractor initials _____ Date _____ CDC # _____

PHYSICAL EXAM FINDINGS (ER and admission note, plus neuro consult)

Exam Finding	Yes	No	Unknown	Date / time first reported
Alert and Oriented	☐	☐	☐	
Extraocular Palsy	☐	☐	☐	
If yes, is it bilateral	☐	☐	☐	
If yes, is it symmetric	☐	☐	☐	
Ptosis	☐	☐	☐	
If yes, is it bilateral	☐	☐	☐	
If yes, is it symmetric	☐	☐	☐	
Pupils dilated	☐	☐	☐	
If yes, is it bilateral	☐	☐	☐	
Pupils constricted	☐	☐	☐	
If yes, is it bilateral	☐	☐	☐	
Pupils non-reactive	☐	☐	☐	
If yes, is it bilateral	☐	☐	☐	
Facial paralysis	☐	☐	☐	
If yes, is it bilateral	☐	☐	☐	
If yes, is it symmetric	☐	☐	☐	
Palatal weakness	☐	☐	☐	
Impaired gag reflex	☐	☐	☐	
Sensory deficits	☐	☐	☐	
Other	☐	☐	☐	

Notes:

Musculoskeletal Exam

Upper Extremity	Proximal	R: /5	L: /5	Distal	R: /5	L: /5
Lower Extremity	Proximal	R: /5	L: /5	Distal	R: /5	L: /5

Deep Tendon Reflexes

Upper Extremity	Bi/triceps	R: /4	L: /4	Brachial	R: /4	L: /4
Lower Extremity	Patellar	R: /4	L: /4	Ankle	R: /4	L: /4
Is muscle weakness / paralysis present, describe progression	☐ Ascending ☐ Descending					

Notes:

CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016

Abstractor initials _____ Date _____ CDC # _____

CLINICAL TESTS (ER and admission note, plus neuro consult)

Test	Yes	No	Unknown	
Lumber puncture	☐	☐	☐	Date:
If yes	WBC:	RBC:		Glucose: Protein:
EMG	☐	☐	☐	Date:
With rapid, repetitive stimulation	☐	☐	☐	Hertz:
Suggestive of botulism	☐	☐	☐	
Endophonium (Tensilon)	☐	☐	☐	Date:
Findings:				
CT scan or MRI scan	☐	☐	☐	Date:
Findings:				
Toxicology screen	☐	☐	☐	
Urine				
Serum				
Blood Alcohol Conc.				
Alcohol Panel				
Electrolytes on admission	☐	☐	☐	
Na (sodium)				
K (potassium)				
Cl (chloride)				
HCO_3 (bicarbonate)				
BUN				
Creatinine				
Glucose				
Other diagnostic tests or labs	☐	☐	☐	

Notes:

CHART ABSTRACTION FOR PRISON OUTBREAK OF *CLOSTRIDIUM BOTULINUM*
JUNE 2016

Abstractor initials _____ Date _____ CDC # _____

CLINICAL COURSE

Admitted to the ICU: ☐ Yes ☐ No If yes, date _____

Intubated: ☐ Yes ☐ No If yes, date _____

Respiratory muscle strength used to predict need for intubation

Test name	Value on admission	Value on "worst" measurement	Date and time of "worst" measurement
NIF (negative inspiratory flow)			
MIP (maximal inspiratory pressure)			
MEP (maximal exspiratory pressure)			
SNIP (sniff nasal inspiratory pressure)			

Tracheostomy: ☐ Yes ☐ No If yes, date _____

Administered HBAT: ☐ Yes ☐ No If yes, date _____ Time _____

Adverse effects: ☐ Anaphylaxis ☐ Infusion Reaction

☐ Hemodynamic instability ☐ Other: _____

Date that neurologic improvement was noted: _____

Outcome: Date _____

☐ Discharged alive ☐ Died ☐ Transfer _____

☐ Still hospitalized ☐ Other _____

Notes:

Additional notes:

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

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

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

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

1. CDC 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: _____ ☐ Teleconference

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

7. Staff present for interview: ☐ State Health ☐ Correctional facility ☐ CDC ☐ Other (Specify): _____

8. Current cell/housing unit: _____

9. Cell/housing unit on June 1st: _____
Different from current cell/housing unit? ☐ Yes ☐ No ☐ Unknown
If yes, when did the inmate change cell/housing unit?: __ __ / __ __ / __ __ __ __ Notes: _____
M M D D Y Y Y Y

10. Inmate duty assignment (kitchen staff, janitorial, etc.): _____

Section 2: INMATE DEMOGRAPHIC DATA:

1. Age: _____ years

2. Sex: ☐ Male ☐ Female ☐ Unknown

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

4. Do you identify as Hispanic or Latino origin? ☐ Yes ☐ No ☐ Unknown

Section 3: FOOD ALLERGIES, SPECIAL DIETS: I am going to ask you questions about your diet.

Yes	Maybe	No	Don't Know	Did you have:
☐	☐	☐	☐	1. Any allergies that prevent you from eating a certain food(s)?
				1a. What foods? ☐ Milk ☐ Eggs ☐ Peanuts ☐ Tree nuts ☐ Fish ☐ Soy ☐ Wheat ☐ Shellfish ☐ other: _____ *Please check all that apply*.
☐	☐	☐	☐	2. Do you follow a special or restricted diet?
				Which? _____

Section 3 Comments. *Please fill in any comments/notes from this section in the space provided below:*

Section 4: ALTERNATE SOURCES OF FOOD AND DRINK: Now we are going to ask you about food and drink you may have consumed outside of the prison cafeteria.

Yes	Maybe	No	Don't Know	Since Wednesday, June 1st, have you:
☐	☐	☐	☐	1. **Stored food in your cell?**
				1a. What foods? _____
☐	☐	☐	☐	2. **Consumed food prepared in your cell?**
				2a. What foods? _____ Did you share with other inmates? ☐ Yes ☐ No ☐ Unknown

Yes	Maybe	No	Don't Know	
☐	☐	☐	☐	**3. Stored food in your housing unit?**
				3a. What foods? _____ _____
☐	☐	☐	☐	**4. Consumed food prepared in your housing unit?**
				4a. What foods? _____ _____ Did you share with other inmates? ☐ Yes ☐ No ☐ Unknown
☐	☐	☐	☐	**5. Received food from outside the prison, such as food brought to you by a friend or family member?**
				5a. What foods? _____ _____ Did you share with other inmates? ☐ Yes ☐ No ☐ Unknown
☐	☐	☐	☐	**6. Bought food from the commissary?**
				6a. What foods? _____ _____ Did you share with other inmates? ☐ Yes ☐ No ☐ Unknown
☐	☐	☐	☐	**7. Received food from another inmate (shared, traded, bought)?**
				7a. What foods? _____ _____ Did you share with other inmates? ☐ Yes ☐ No ☐ Unknown

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

Section 5: HOOCH: Now I have a few questions about hooch, brew or pruno. You can skip any question you prefer not to answer.

Yes	Maybe	No	Don't Know	
☐	☐	☐	☐	1. Have you ever drank hooch since you entered the prison? ☐ Refusal
				1a. How often do you drink hooch? ☐ daily ☐ weekly ☐ monthly ☐ less than monthly ☐ when it is available ☐ don't know
☐	☐	☐	☐	2. Do you brew hooch yourself? ☐ Refusal
				If no, do you know how hooch is made? ☐ Yes ☐ No ☐ Don't know
☐	☐	☐	☐	3. Have you drunk hooch since June 1st? ☐ Refusal
				3a. On which days did you drink and how much each day? FILL IN CALENDAR ON THE NEXT PAGE WITH DRINKING HISTORY 3b. What type of container(s) did you receive the hooch in?_____ _____ ☐ Multiple containers *(if multiple indicate on calendar)* 3c. What type of container did you keep the hooch in?_____ ☐ Same container as container received in 3d. Where did you get the hooch? ☐ Refusal_____ _____ _____

				3e. Can you describe the color of the hooch that you drank? _____ _____ ☐ Multiple colors *(if multiple indicate on calendar)* 3f. Do you know when the batch of hooch that you drank was dug up or ready to drink? ☐ Yes ☐ No ☐ Don't know If yes, when? __ __ / __ __ / __ __ __ __ *(if multiple batches, describe in comments)* 3g. Did you share with other people? ☐ Yes ☐ No ☐ Don't know How many people did you share with? _____ Did any of these people go to the hospital? ☐ Yes ☐ No ☐ Don't know How many? _____ 3h. Is the hooch you drank is still available for purchase? ☐ Yes ☐ No ☐ Don't know 3i. Can you tell me anything else about this batch of hooch? _____ _____ _____
☐	☐	☐	☐	4. Before the recent outbreak, did you know hooch could make you sick (more than a hangover)?
☐	☐	☐	☐	5. Before the recent outbreak, had you heard of the illness botulism before?

Section 5 Comments. *Please fill in any comments/notes from this section in the space provided below:*
(Optional questions:
About how many brewers are there?
About how much do they brew per week (how often do they brew)?
How much hooch could you get right now if you wanted to?
How many stamps would a cup of hooch cost?)

JUNE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	2 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	3 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	4 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____
5 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	6 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	7 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	8 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	9 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	10 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	11 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____
12 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	13 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	14 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	15 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	16 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	17 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____	18 Drank? Yes No How much? ( ) Sip ( ) Cup ( ) Pint ( ) More than a pint Color:_____ Source:_____ Container:_____

Section 6: CLINICAL INFORMATION:. I am now going to ask you about your current illness and symptoms.

1. What day/time did you first feel sick? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) Time: __ __ : __ __ AM / PM ☐ Not sick (**Skip to Section 8**)
2. What day/time did you first report your symptoms to correctional staff? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) Time: __ __ : __ __ AM / PM
3. What day/time did you first see a doctor? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) Time: __ __ : __ __ AM / PM
4. Were you hospitalized? ☐ Yes ☐ No ☐ Don't know

   When? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) Time: __ __ : __ __ AM / PM

   Where were you first hospitalized? _____
5. How many days total were you sick? _____ days *(enter 999 if unknown)* or ☐ Still Ill

At any point during your illness, have you had:

Yes	No	Don't Know	Symptom
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Abdominal Pain
☐	☐	☐	Dry mouth
☐	☐	☐	Hoarseness, or change in sound of voice
☐	☐	☐	Slurred Speech
☐	☐	☐	Difficulty swallowing
☐	☐	☐	Thick tongue
☐	☐	☐	Shortness of breath
☐	☐	☐	Blurred Vision
☐	☐	☐	Double vision
☐	☐	☐	Dizziness
☐	☐	☐	Weakness
☐	☐	☐	Fatigue
☐	☐	☐	Numbness or tingling

Clinical history:

At any point in your life have you been told by a doctor that you have any of the following illnesses:

Yes	No	Don't Know	Comorbidity
☐	☐	☐	Diabetes
☐	☐	☐	Hypertension
☐	☐	☐	TB
☐	☐	☐	Hepatitis C
☐	☐	☐	HIV
☐	☐	☐	Other chronic illness?
			Which other(s)?_____

Section 6 Comments.

Section 7: Medications: I will now ask you about medication, tobacco, and other substance use since June 1st. You can skip any question/s you do not want to answer.

Yes	Maybe	No	Don't Know	Since June 1st, have you:
☐	☐	☐	☐	1. Do you currently smoke cigarettes or other tobacco product(s)? ☐ Refusal
				How often? ☐ at least once a day ☐ at least once a week ☐ at least once a month ☐ when it is available ☐ don't know If daily, how many cigarettes/tobacco per day on average?_____ (Specify_____)
☐	☐	☐	☐	2. Do you currently chew tobacco or dip? ☐ Refusal
				How often? ☐ at least once a day ☐ at least once a week ☐ at least once a month ☐ when it is available ☐ don't know
☐	☐	☐	☐	3. Taken any over the counter medication(s)?
				Which?_____
☐	☐	☐	☐	4. Taken medication(s) that was prescribed to you by a doctor?
				Which?:_____
☐	☐	☐	☐	5. Taken any prescription medication(s) that was NOT prescribed to you by a doctor?
				Which?_____
☐	☐	☐	☐	6. Have you smoked, snorted, or ingested any drug(s) for recreational use? ☐ Refusal
				Which? ☐ Marijuana ☐ Cocaine/crack ☐ Methamphetamine ☐ Hallucinogen (Specify:_____) ☐ Other (Specify:_____)
☐	☐	☐	☐	7. Have you injected any drug(s) for recreational use? ☐ Refusal
				Which? ☐ Cocaine ☐ Heroin ☐ Other (Specify:_____)

Section 3 Comments. *Please fill in any comments/notes from this section in the space provided below:*

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

DETAILED ENTERICS QUESTIONNAIRE

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

Thank you for all of the information you gave us so far. We are still working hard to try to understand what caused you to become ill with Elizabethkingia infection.

Because you reported consuming some fruit or nuts in previous interviews, we have a few more specific questions about what fruit or nuts you might have had before you became ill in 2015 or 2016, when you might have consumed these foods, and how they were packaged.

1. **Did you consume fruit or nuts purchased in bulk from a truck, delivery or mail order service, or receive fruit or nuts from someone you know who uses one of these services in 2015 or 2016, before you became ill?**

   Yes No Maybe

2. **Did you purchase or receive any fruit or nuts, or items that contain fruits or nuts, from any of the following sources in 2015 or 2016, before you became ill? This could include any fruits or nuts that you did not consume.**

   Via home delivery or mail order? Yes No Maybe
   Company/Business name: _____
   Street address: _____
   City _____ State _____ Date(s) of delivery _____

   Pick-up from truck or other pick-up location? Yes No Maybe
   Pick-up location/business name: _____
   Street address: _____
   City _____ State _____ Date(s) of pick-up _____

   From a friend, family member, or co-worker? Yes No Maybe
   Name of friend/family member: _____
   Telephone number: _____Date(s) _____

   From a fundraiser (e.g., school, church, FFA)? Yes No Maybe
   Name of organization/ school /club: _____
   Street address: _____
   City _____ State _____ Date(s) of pick-up _____

   From a farmer's market? Yes No Maybe
   Market name/location: _____
   Street address: _____
   City _____ State _____ Date(s) of pick-up _____

   From another source (specify)? Yes No Maybe
   Location/source: _____
   Street address: _____
   City _____ State _____ Date(s) of pick-up _____

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

3. Which of the following fruit or nuts, or items that contain fruits or nuts, did you purchase or consume from the above source(s)? (please circle)

Specific fruit/nuts	**Source of fruit/nuts based on above information**
Blueberries	
Peaches	
Grapefruit	
Honeybells / Minneola tangelos	
Oranges (any type)	
Navel oranges	
Cranberries	
Dried fruit	
Other fruit purchased in bulk from the above source (specify) _____	
Pecans	
Chocolate-covered pecans	
Other nut purchased in bulk from the above source (specify) _____	

4. For the fruits that you reported having in 2015 or 2016 before you became ill (see question 3), please answer each item individually by circling Yes, No, or Maybe and provide as many details as possible.

Produce / Beverages / Nuts					
Item	**Y**	**N**	**M**	**Unk**	**Additional information: variety or brand, purchase location, how prepared, when and where consumed etc.**
Fruits					
Blueberries	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____

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PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

					Date(s) consumed: _____ If you froze, made, or received anything with the blueberries, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Peaches (fresh, frozen, in desserts or jams/preserves)	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s)received (if not purchased): _____ Date(s) consumed: _____ If you froze or made, or received anything with the peaches, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Grapefruit	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, made, or received anything with the grapefruit, have you used or eaten them since? Y / N / Not sure _____ _____ _____

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

					Are there any left? Y / N / Not sure
Honeybells / Minneola tangelos	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, made, or received anything with the honeybells, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Orange(s) (any type)	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the oranges, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Navel oranges	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

					Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the navel oranges, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Cranberries (fresh, frozen, dried, in desserts or sauces)	Y	N	M	Unk	Fresh / frozen / dried / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the cranberries, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Other fresh fruit purchased in bulk	Y	N	M	Unk	Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the fruit, have you used or eaten them since? Y / N / Not sure _____

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

					_____ _____ Are there any left? Y / N / Not sure
Dried fruit purchased in bulk	Y	N	M	Unk	Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the fruit, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Other fruit purchased in bulk	Y	N	M	Unk	Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the fruit, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Nuts					
Pecans (by themselves or in pies, desserts, ice cream, cheese ball)					Not in shell / in-shell (circle) Fresh / frozen / in desserts or jams/preserves (circle) Description/type: _____

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

					Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the pecans, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Chocolate-covered nuts					Specify nut: _____ Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the nuts, have you used or eaten them since? Y / N / Not sure _____ _____ _____ Are there any left? Y / N / Not sure
Other nuts purchased in bulk	Y	N	M	Unk	Description/type: _____ Where purchased: _____ Date(s) purchased: _____ Where received (if not purchased): _____ Received from (if not purchased): _____ Dates(s) received (if not purchased): _____ Date(s) consumed: _____ If you froze, received, or made anything with the nuts, have you used or eaten them since? Y / N / Not sure _____

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

					_____ _____ Are there any left? Y / N / Not sure

5. **How were these fruits or nuts (or items with fruits or nuts) packaged when you purchased or received them?**
   _____

6. **Did you freeze any of the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?**
   Yes No Maybe

7. **Did you dry/dehydrate any of the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?**
   Yes No Maybe

8. **Did you make jams or preserves from any of the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?**
   Yes No Maybe

9. **Did you make anything from else from the above fruits/nuts purchased or received in 2015 or 2016, before you became ill?**
   Yes No Maybe

10. **Did you give or donate any of the above fruits/ nuts to other people or facilities in 2015 or 2016, before you became ill?**
    Yes No Maybe

11. **Did you eat at the following restaurants, or receive any food from the following restaurants located in Milwaukee, during 2015 or 2016, before you became ill?**

    Honeypie Café
    Yes No Maybe

    Lulu Café
    Yes No Maybe

    Palomino Bar
    Yes No Maybe

    Juniper 61
    Yes No Maybe

INTERVIEW DATE: _____/_____/_____ **INTERVIEWER:_____**

PATIENT ID:_____ **CULTURE POSITIVE DATE:_____**

Amilinda
Yes No Maybe

12. **Did you receive any products from Tree Ripe Citrus during 2015 or 2016, before you became ill?**
Yes No Maybe

13. **Did you receive any products delivered by Spee-dee Delivery regional shipping company during 2015 or 2016, before you became ill?**
Yes No Maybe

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ETHNOGRAPHIC INTERVIEW GUIDE

Public reporting burden of this collection of information is estimated to average 120 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

Patient identifier 1: _____	Date of Positive Elizabethkingia Test PI 1: ___/___/_____	Patient History PI 1: _____ _____ _____ _____ _____
Patient identifier 2: _____	Date of Positive Elizabethkingia Test PI 2: ___/___/_____	Patient History PI 2: _____ _____ _____ _____ _____
Patient identifier 3: _____	Date of Positive Elizabethkingia Test PI 3: ___/___/_____	Patient History PI 3: _____ _____ _____ _____ _____
Patient identifier 4: _____	Date of Positive Elizabethkingia Test PI 4: ___/___/_____	Patient History PI 4: _____ _____ _____ _____ _____
Patient identifier 5: _____	Date of Positive Elizabethkingia Test PI 5: ___/___/_____	Patient History PI 5: _____ _____ _____ _____ _____

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

I. Daily activities

I. Typical daily routine

Our first step will be to have everyone to introduce themselves. Let's go around the room and have you say your name as it appears on your name card. Remember, this can just be a made up name, if you want it to be; we just want a way to be able to identify each of you during the discussion today.

Along with your name, I would like to ask you about some of your daily activities in the 3 months before you got ill [refer to calendar visual for everyone.] Could you tell me VERY briefly what do you all do on a typical day or week? We can just quickly go around the room. [Gauge discussion of below topics based on responses from participants. Limit to about 2 minutes per person]

I. Home environment

1. Could you describe where you live? Tell me about your neighborhood.
    a. Are you in an urban or rural area?
    b. Who else lives in your household?

II. Consumption of foods and drinks

Thank you for sharing this information with us. Now we're going to specifically talk about what you ate or drank you did in the 90 days before you became ill.

1. What did you eat and drink on a typical day from during the 3 months before you became ill?
    a. How is your food typically prepared?
        i. Do you cook your own food?
        ii. Do you get your food from the grocery store?
        iii. Do people bring you food? (either prepared or from a grocery store)
            a. Probe for: fruit or pecan pies, ice creams with fruit or pecans, jams/jellies, specifically oranges, grapefruit, tangelos, honeybells, blueberries, peaches
            b. Fruit baskets? (especially around the holidays)
        iv. Do you eat packaged or frozen foods?
        v. If your food comes from a market, does it come from…
            a. A regular grocery store?
            b. Local store or farmer's market?
            c. Ethnic markets?
        vi. Do you get your food from other sources, like:
            a. Bulk food shops

b. Food delivery trucks or systems, e.g., Schwann's, seafood truck, FFA
c. Specially ordered bulk fruit, typically brought in from out of state that you or someone you know ordered (if yes use fruit supplemental)
d. Fruit as gift, in gift baskets or seasonally delivered (if yes use fruit supplemental)
e. Specifically ask about Tree Ripe Citrus Fruit company? (mail order/pick up)
    i. If picked up food from Tree Ripe Citrus, which location?
    ii. Pick up from high school; from door-to-door sellers
f. Do you freeze fruit? If so, how old is this fruit (if you buy in bulk, how long does your supply last in the freezer)? Do you still have the fruit from the time period in question? (**Is it available for testing?)

iii. Probe for pecans, oranges, grapefruit, tangelos, honeybells, blueberries, peaches from this or other delivery trucks during 2015

2. Did you go to any restaurants during this time? If so, did you consume any…
    a. Dairy?
    b. Meats?
    c. Seafoods?
    (Have participants elaborate)
    d. Did you eat at: Honeypie Café, Lulu Café, Palomino Bar, Juniper 61, Amilinda in Milwaukee? (these restaurants serve products that contain Tree Ripe Citrus products)

3 . Now I'd like to ask specifically about food you may have eaten that would have been produced locally, meaning somewhere in South or Southeastern Wisconsin.
    a. Dairy (milk, cheese, yogurt)
        Spreadable cheese
        Artisanal cheese or from a local cheesemaker
    b. Produce (fruits, vegetables)
        i. Sources of fruit: fruit delivery trucks, fruit stand on side of road or in parking lots
        ii. Do you freeze fruit? If so, how old is this fruit (if you buy in bulk, how long does your supply last in the freezer)? Do you still have the fruit from the time period in question? (**Is it available for testing?)
        iii. Mail order any fruit?
        iv. Probe for pecans, oranges, grapefruit, tangelos, honeybells, blueberries, peaches from this or other delivery trucks during 2015
    c. Meats (hunted, grocery store, fresh vs. processed such as sausages or salami)
    From local meat markets or butcher shops
    Did you receive or order any holiday or specialty meat/cheese baskets or gifts
    d. Seafood
4. Did you drink any…
    a. Alcohol? (probe for any new or local alcoholic drinks like beer or wine)

b. Juices? (probe for new or local juices)
c. Teas? (e.g., kombucha, herbal)
d. Milk? (probe for unpasteurized sources)

5. Did you use any local spice blends?

III. Employment

Thank you for telling us about your experiences so far. We know this is a long discussion so we appreciate your patience. We will now talk a little bit about where you might have worked or volunteered outside your home in the 3 months before you became ill. Even though we are moving on to a different topic, you can feel free to tell us at any point if there is something you might have forgotten to tell us earlier.

1. Did you work or volunteer outside your home during the 3 months before you became ill? How would you describe your work environment (Was it dusty or clean? Was it a warehouse or office building)?
2. What kind of work did you do? Describe what your typical day was like.
    a. Welding
    b. Factory work
    c. Farm/garden
    d. Office work
3. Did you work in areas that had a lot of:
    a. Dust?
    b. Sawdust or other small particles?
    c. Chemicals around the area?
4. Did you interact with many people around you while working?
    a. How many people did you typically interact with daily?
    b. Do you remember if any of these people were typically healthy or at all ill?
5. Were there any birds or other animals nesting in areas where you were working?
6. Were there many insects in the area where you worked?

IV. Leisure activities/hobbies

Now we will talk about how you spend your free time. This can include any hobbies or pastimes you might have. Could we quickly go around the room and talk about how you spent your free time in the 3 months before you became sick? [Limit to 2 minutes per person]

1. Do you like to spend time outdoors? If so, tell me what that looked like during the 3 months before you got sick when you were not traveling. For example, did you do any:
    a. Hunting

i. Location of activity:
ii. Frequency of activity:
iii. How many other people were involved and how often?:

b. Bird watching
   i. Location of activity:
   ii. Frequency of activity:
   iii. How many other people were involved and how often?:
c. Hiking
   i. Location of activity:
   ii. Frequency of activity:
   iii. How many other people were involved and how often?:
d. Gardening
   i. Location of activity:
   ii. Frequency of activity:
   iii. How many other people were involved and how often?:
e. Fishing
   i. Location of activity:
   ii. Frequency of activity:
   iii. How many other people were involved and how often?:
f. Any other outdoor activities that you might think of?

2. Now I'd like to discuss time you've spent around animals. First, I am going to ask if any of you had a variety of different exposures. Please say yes or raise your hand if you had the exposure. Then we will talk about some of them in more detail. Did you spend time with or were around any of the following:
   a. Household pet, even if you didn't touch it (cat, dog, rabbit)
   b. Farm animals
   c. Wild Birds (birdbath, birdfeeder, waterfowl watching or hunting)
   d. Other wild animals (e.g., deer hunting)
   e. Did you visit any areas with animals, such as farms, petting zoos, gardens or green spaces?
   f. Mice, rats (such as handling a mousetrap)
   g. Did you find insects in or around your home or anywhere you might have spent a lot of time during this period? Did you get any insect bites? Did a pet have insect bites, such as from fleas or ticks?
   h. Any other animal exposures you'd like to share?
3. Did you go to any social gatherings or regular meet-ups with friends or family? This could be on a routine basis (like you go play cards every Saturday night) or gatherings that you might have attended for special occasions.
   a. What did you do during these gatherings? Where were they?
   b. What did you eat?

c. What did you drink?
d. Did you smoke any tobacco or other products?
e. Do you consume any tobacco or illicit products?

4. Did you keep any plants or flowers around the house, either inside or outside?
    a. What kind of plants? (Probes: from where, newly acquired?, did patient plant or re-pot them)
        i. Did you have any seasonal plants? (this can include things like cacti, poinsettias, Christmas tree, Easter lilies…)
    b. How did you take care of these plants? (e.g., water, re-pot them, give plant food or fertilizer if needed)
    c. Were there cut flowers in your home?
        i. Were these plants/flowers from your garden or somewhere else?
        ii. Were the plants/flowers delivered? (probe for source)
    d. Were there cut flowers or plants anywhere else you spent time? This could be at work, in a hospital, at a family member's home, etc.

V. Health and wellness activities

Thank you for sharing your experiences with us so far. We know this is a long discussion so we appreciate your patience. I know we have talked a lot in the past about your medical care before you got sick. Now we're going to ask you about some wellness activities and some other activities in the 3 months before you became ill. Even though we are moving on to a different topic, you can feel free to tell us at any point if there is something you might have forgotten to tell us earlier.

1. Did you receive any massages during this time?
2. Did you receive acupuncture?
3. Did you receive any other health-related treatments that you did not get from your physician's office? (like alternative or holistic medicine)?
    a. Did you go to a pain clinic?
    b. Did you take anything, or receive any injections, to help with your health that you did not receive at your physician's office?
4. Did you ever visit a sauna or hot tub?
5. Did you take any products or supplements for your health and wellness, such as…
    a. Probiotics
    b. Herbal teas
    c. Other supplements or vitamins
6. Did you do anything for exercise during this time?
    a. What do you do for exercise? Where do you exercise?
    b. Did you attend any gyms or exercise classes? What kind of classes did you attend, if any?
    c. Did you ever visit a swimming pool or water park?

7. Did you use a neti-pot?

VI. Any visitation periods/ travel

Let's now talk about any travel you might have had or times when someone (such as a family member or friend) came to visit you during the 3 months before you became ill. For the purpose of our conversation, travel is anywhere outside your home where you stayed for the day, or overnight. This could include routine travel or travel for special occasions.

1. Did you travel during the 3 months before you became ill?
    a. Where did you go? When?
    b. For how long did you travel during each of these trips?
2. Did anyone visit you during the 3 months before you became ill?
    a. Who visited you?
    b. How long did they visit you? (Were these regular visits?)

For each travel or visitation period, ask the following:

3. What was the purpose of your travel / visitation period (if visited by someone)?
    a. Visit family
    b. Vacation
    c. Work
    d. Event
4. Who did you see during this travel / visitation period?
    a. What was the occupation of these people?
    b. Did anyone have much contact with **[especially probe for people with outdoor occupations and grandchildren]**:
        i. Dirt or soil?
        ii. Plants?
        iii. Insects?
        iv. Animals?
        v. Manure?
        vi. Chemicals?
5. How did you spend your time? (prompts: dining out, shopping, spa, gym, outdoor activities)
    a. Did you participate in any outdoor activities?
        i. Hunting
        ii. Bird watching
        iii. Hiking
        iv. Gardening
        v. Fishing
    b. Did you spend time with animals? This includes time spent around household pets or farm animals, as well as visiting a petting zoo or aquarium.

i. What animals did you interact with? (e.g., dog, cat, fish in fish tank, exotic animals)
ii. Tell me more about time spent with this animal.

c. Did you go to any social gatherings or events with family or friends?
d. Where did you eat or drink on these trips… (restaurant, family/friend house, brought food from home)
   i. Did you have any…
      1. Local or home brews of alcohol beverages (e.g., beer, wine)
      2. Homemade beverages, such as sodas or teas
      3. Fermented drinks, like kefir
      4. Local dairy products, like milk, cheese, or yogurt?
      5. Local produce, like fruits or vegetables?
      6. Meats?
         a. Game meats obtained through hunting
         b. Meats obtained from butcher or grocery store
         c. Processed meats, like sausages or meat sticks?
e. Did you smoke or spend time with people who were smoking tobacco or other products? Smoking includes cigarettes, e-cigarettes, pipes, cigars, and water pipes, often called hookahs.
   (if yes - what were they smoking?, where? Who was smoking if it wasn't the patient?)

VII. Miscellaneous

1. Did it snow in the 3 months before you became ill? If so, did you or someone else shovel snow from around where you live? If so, did you or they use any products to treat ice, like gravel, salt, or kitty litter?
2. How did you heat your home?
   a. Did you have central heat?
   b. Did you use a wood stove, pellet stove, or fireplace? If so, what did you burn in the fireplace?
3. Did you go anywhere else, either inside or outside (e.g., neighbor or friend's home, outside next to fire pit), with another source of heat?
2. Did you have any home deliveries during the 3 months before you became ill?
   a. Regular delivery of medicines or other items?
   b. Special deliveries of gifts or ordered items?
   c. Did you receive any deliveries of flowers?
   d. Did you receive deliveries of fruit or nuts from anywhere? (probe for Tree Ripe fruit)
      Specifically: pecans, oranges, grapefruit, tangelos, honeybells, blueberries, peaches
   e. Do you remember which company might have delivered these items (fedex, ups, usps)?
3. Did you take any free samples of items, such as foods, drinks lotions, soaps from any stores or through the mail during the 3 months before you got sick?

Interviewer: _____
Date: _____ Time: _____ AM/PM
Location: _____ Focus Group #: _____

Thank you again for all of your responses. We so appreciate all of your patience. As you might know, we have talked to a lot of people and spent a lot of time trying to figure out what is causing people to become ill with this infection. We are still looking for clues as to what happened. Could you all briefly tell me what YOU think might have caused you to become sick?

[Limit this to < 5 minute discussion.]

[COLLECT ACTIVITY SHEETS BEFORE EVERYONE LEAVES.]

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

Undetermined Mode of Transmission: Zika Virus among Utah Community Members, 2016

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Household Member Log

Household ID

Home Address

Street address: _____

City: _____ State: _____ Zip: _____County: _____

(*Best way to contact them in the future*) Phone: _____or e-mail: _____

List first and last name for each person who meets definition of a Household Resident and verify that they have been at this address for the last month.

Can you tell me the names of all the people who stayed in your house for at least two nights per week since mid-June (June 15) until now?

No.	**Name of Resident**	**Age (***Record in complete months if child <2 years)		**Sex**	**Record of consent for INTERVIEW**	**Date interview conducted**	**Record of consent for SPECIMENS**	**Specimens collected**
01			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
02			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
03			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
04			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None

05			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
06			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached)	o Blood o Urine o None
07			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
08			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
09			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
10			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
11			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None
12			o years o months	o F o M	o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached		o Consent obtained o Consent refused o Parental consent provided o Parental consent refused o Person never reached	o Blood o Urine o None

Community Evaluation Questionnaire

HH ID:_____

Interviewer Information

Interviewer Name (First, Last): _____

State/Local/Territorial Health Department: _____

Language survey was conducted in: _____

Informant Information o Not applicable

If not the specific individual, who is providing information for this form?

HH ID Number: _____

Relationship to resident: _____

Reason individual unable to provide information him/herself:

o Child o Mentally handicapped o Other: _____

Exposures

Now I would like to ask you about your time outdoors or potential exposure to mosquitoes.

Since June 15, 2016, how much time on average have you spent outdoors each day?

o less than 1 hour o 1-4 hours o 5-10 hours o more than 10 hours o Don't know

How often did you wear mosquito repellant when you were outdoors for 15 minutes or more?

o Always o Most of the time o Sometimes o Never o Don't know

Since June 15, 2016, did you get any mosquito bites?

o Yes o No o Don't know

For windows and outside doors that you have left open this summer, how many of these have screens?

□ [illegible]

□ [illegible]

Resident's Travel and Potential Flavivirus exposure

Now I would like to ask you about if you might have been exposed to Zika virus or related viruses before.

Did you travel outside the United States (or to a US territory: Puerto Rico, USVI, Am Samoa) in the last year (since July 2015)? o Yes o No

If yes: Name of country(s): _____

Dates of travel: Start date:____/_____/_____ End date: ____/_____/_____

Name of country(s): _____

Dates of travel: Start date:____/_____/_____ End date: ____/_____/_____

Name of country(s): _____

Dates of travel: Start date:____/_____/_____ End date: ____/_____/_____

Name of country(s): _____

Dates of travel: Start date:____/_____/_____ End date: ____/_____/_____

Name of country(s): _____

Dates of travel: Start date:____/_____/_____ End date: ____/_____/_____

Name of country(s): _____

Dates of travel: Start date:____/_____/_____ End date: ____/_____/_____

Were you born or lived for several years outside the United States? o Yes o No o Unknown

If yes, where? _____

Medical Information

Since June 15, 2016, have you had any of these symptoms? We are talking about symptoms that would have been new for you, not long standing problems?

Fever o Yes o No If yes, first date with this ____/_____/_____

How many days did it last? _____

(Note, here we would count their report of subjective fever. Interviewer, please use calendar aid)

Rash o Yes o No If yes, first date with this ____/_____/_____

How many days did it last? _____

(here we are NOT asking about a rash that was just on one arm or one leg, like poison ivy)

Conjunctivitis (redness of the white part of the eyes)

o Yes o No If yes, first date with this ____/_____/_____

How many days did it last? _____

(here we are NOT asking about red, itchy eyes that you may know you get because of allergies)

Joint Pain o Yes o No If yes, first date with this ____/_____/_____

How many days did it last? _____

(here we are NOT asking about pain that was definitely from an injury)

For this illness, did you go to a clinic/hospital to be checked? o Yes o No

If yes, what did the doctor/nurse decide that you had? _____

((Use this additional space if more than one episode, or additional notes))

For females age ≥12 years and <45 years: Are you pregnant or think you might be pregnant?

o Yes o No o Unknown

Information related to blood specimens and interpretation of results

***If NO blood specimen is consented for*. Thank you again for your willingness to provide the information. If we have any additional questions, is it okay to contact you again**?

o Yes o No (If yes, verify contact details on household list)

If blood specimen is consented for, complete specimen collection form, and ask these additional questions:

We would like to ask you just a few more questions about your health so we can better understand your blood test results.

To the best of your knowledge, have you ever received these vaccines (these are vaccines that may be given to persons who travel out of the country)

Yellow fever vaccine o No o Unsure o Yes, year of last dose_____

Japanese encephalitis vaccine o No o Unsure o Yes, year of last dose_____

Tick-borne encephalitis vaccine o No o Unsure o Yes, year of last dose_____

Has your doctor told you that you have any medical conditions that limit your ability to fight infections?

o Yes o No o Unknown

Are you taking any medications that suppress your immune system?

o Yes o No o Unknown

In the past 2 months, did you receive a blood transfusion or organ transplant?

o Yes o No o Unknown

For this last question, we will ask you to read it and point to the answer.

In the last year, have you ever had unprotected sex with someone who had recently returned from a country where Zika has been spreading? (By recently returned, we mean your partner had returned sometime during the 2 months *before* the time you had unprotected sex)

Your Answer o Yes o No o Unknown

Thank you very much for your willingness to answer these questions and provide a blood sample.
We will next contact you directly about your results of the blood test. It may take several weeks to get the final results.

Form Approved
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Healthcare Personnel Risk Assessment Questionnaire and Serosurvey for Zika Virus Exposure—Utah, 2016

Public reporting burden of this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

ID _____ _____ _____ _____ _____

Zika Virus Exposure Assessment for

Healthcare Personnel

Date of interview:

Name of interviewer:

Subject name:

Job Title:

Is contact information correct?

If no, please provide

Address:

Phone:

Where was interview administered (circle one)?

Wellness clinic
Phone
Home
Other (please specify)_____

Has sample been collected?

Yes
No
Not indicated at this time

Case or Control (circle one)

ID _____ _____ _____ _____ _____

Section 1: Demographics, Role----------

1. Gender ☐ Male ☐ Female

2. Age _____ years

3. Please indicate your job title at this facility

☐ Laboratory staff ☐ Environmental services ☐ Nurse ☐ Radiology tech

☐ Physician/Advanced Care Provider ☐ Respiratory therapy ☐ Certified nursing assistant/Health care assistant

☐ Other (please specify) _____

4. How long have you been working in your current role (at any facility)? _____ months/years

Section 2: Risks and symptoms----------

Country of origin:

Have you lived outside of the US? ☐ Yes ☐ No

If yes, what countries have you lived in and when did you live there?

Country	Start date	End date

Travel history (past year)

Region/country	Start date (XX/XX/XXXX)	End date (XX/XX/XXXX)
Mexico		
Cape Verde		
Caribbean (please specify) _____		
Puerto Rico		
Central America (please specify) _____		
Pacific Islands (please specify) _____		
South American (please specify) _____		
Africa (please specify) _____		
Asia (please specify) _____		

Vaccination history

Previous vaccinations:
☐ Yellow Fever Last dose:
☐ Tick-borne Encephalitis Last dose:
☐ Japanese Encephalitis Last dose:

Pregnancy

Are you or your partner currently pregnant?	☐ **Yes** ☐ **No** ☐ **Unknown**	**If yes, test (group A)**
Are you or your partner trying to become pregnant now?	☐ **Yes** ☐ **No** ☐ **Unknown**	**If yes, test (group A)**

ID _____ _____ _____ _____ _____

Are you or your partner planning to become pregnant in the next 6 months?	☐ **Yes** ☐ **No** ☐ **Unknown**	**If yes, test**

Symptoms (developed since patient interaction)

Fever ☐ Yes ☐ No If yes, dates _____ to _____ ☐ Subjective ☐ Measured (Max measured temperature: _____F/C)	Rash ☐ Yes ☐ No If yes, dates _____ to _____ Type: ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Other Pruritic: ☐ Yes ☐ No Distribution:_____
Arthralgia ☐ Yes ☐ No If yes, dates _____ to _____	Conjunctivitis ☐ Yes ☐ No If yes, dates _____ to _____

Do they have 2 or more symptoms occurring within one week?

If no	☐ Asymptomatic
If yes	☐ **Symptomatic**

If symptomatic, are you currently symptomatic or have been symptomatic in the past 14 days?

☐ No	
☐ **Yes**	**Call Dr. Rubin for further instructions**

If symptomatic, were symptoms more than 14 days ago?

☐ No	
☐ **Yes**	**If yes, test (group B)**

Section 4: PPE training----------

Have you received training on proper selection of PPE for standard precautions? ☐ Yes ☐ No

Have you received training on how to don:

- Gloves? ☐ Yes ☐ No
- Gown? ☐ Yes ☐ No
- Eye protection? ☐ Yes ☐ No

Have you received training on how to doff (so as not to contaminate):

- Gloves? ☐ Yes ☐ No
- Gown? ☐ Yes ☐ No
- Eye protection? ☐ Yes ☐ No

How often does this training occur? _____

When did you last receive training? _____

Were you required to demonstrate competency? ☐ Yes ☐ No

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Healthcare Personnel Risk Assessment Questionnaire and Serosurvey for Zika Virus Exposure—Utah, 2016

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ID _____ _____ _____ _____ _____

Zika Virus Exposure Assessment for

Healthcare Personnel

Date of interview:

Name of interviewer:

Subject name:

Job Title:

Is contact information correct?

If no, please provide

Address:

Phone:

Where was interview administered (circle one)?

Wellness clinic
Phone
Home
Other (please specify)_____

Has sample been collected?

Yes
No
Not indicated at this time

Case or Control (circle one)

ID _____ _____ _____ _____ _____

Section 1: Demographics, Role----------

1. Gender ☐ Male ☐ Female

2. Age _____ years

3. Please indicate your job title at this facility

☐ Laboratory staff ☐ Environmental services ☐ Nurse ☐ Radiology tech

☐ Physician/Advanced Care Provider ☐ Respiratory therapy ☐ Certified nursing assistant/Health care assistant

☐ Other (please specify) _____

4. How long have you been working in your current role (at any facility)? _____ months/years

Section 2: Risks and symptoms----------

Country of origin:

Have you lived outside of the US? ☐ Yes ☐ No

If yes, what countries have you lived in and when did you live there?

Country	Start date	End date

Travel history (past year)

Region/country	Start date (XX/XX/XXXX)	End date (XX/XX/XXXX)
Mexico		
Cape Verde		
Caribbean (please specify) _____		
Puerto Rico		
Central America (please specify) _____		
Pacific Islands (please specify) _____		
South American (please specify) _____		
Africa (please specify) _____		
Asia (please specify) _____		

Vaccination history

Previous vaccinations:
☐ Yellow Fever Last dose:
☐ Tick-borne Encephalitis Last dose:
☐ Japanese Encephalitis Last dose:

Pregnancy

Are you or your partner currently pregnant?	☐ **Yes** ☐ **No** ☐ **Unknown**	**If yes, test (group A)**
Are you or your partner trying to become pregnant now?	☐ **Yes** ☐ **No** ☐ **Unknown**	**If yes, test (group A)**

ID _____ _____ _____ _____ _____

Are you or your partner planning to become pregnant in the next 6 months?	☐ **Yes** ☐ **No** ☐ **Unknown**	**If yes, test**

Symptoms (developed since patient interaction)

Fever ☐ Yes ☐ No If yes, dates _____ to _____ ☐ Subjective ☐ Measured (Max measured temperature: _____F/C)	Rash ☐ Yes ☐ No If yes, dates _____ to _____ Type: ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Other Pruritic: ☐ Yes ☐ No Distribution:_____
Arthralgia ☐ Yes ☐ No If yes, dates _____ to _____	Conjunctivitis ☐ Yes ☐ No If yes, dates _____ to _____

Do they have 2 or more symptoms occurring within one week?

If no	☐ Asymptomatic
If yes	☐ **Symptomatic**

If symptomatic, are you currently symptomatic or have been symptomatic in the past 14 days?

☐ No	
☐ **Yes**	**Call Dr. Rubin for further instructions**

If symptomatic, were symptoms more than 14 days ago?

☐ No	
☐ **Yes**	**If yes, test (group B)**

ID _____ _____ _____ _____ _____

Section 3: Patient Interaction----------

Days with any patient interaction?

6/19 6/20 6/22 6/23 6/24 6/25

Site interaction occurred ☐ER ☐ECU ☐Ward ☐ICU ☐Other _____	
☐Patient care ☐Device reprocessing ☐Environmental cleaning ☐Food service needs ☐Other (please specify) _____	
Did you enter patient's room or care area? Yes No	If yes, then low
Did you touch patient? **Yes No**	**If yes, then medium and test (group B)**
Did you (circle all that apply): **Have any contact with blood or body fluids?** **Clean up vomit?** **Clean up stool?** **Draw blood?** **Collect urine sample or empty Foley bag?** **Collect stool sample?** **Wipe away sweat?** **Wipe away tears?** **Suction or manipulate airway?** **Place Foley?** **Place or manipulate rectal tube?** **Reposition the patient?** **Bathe the patient?** **Change linens?** **Perform physical exam?** **Perform radiology exam or Echo?** **Device reprocessing?** **Perform procedure (please specify)?**_____	**If any circled, then high and test (group B)**
Cumulative time in room in hours < 1 hour 1 to 2 hours 59 minutes 3 to 5 hours 59 minutes 6 or more hours	

ID _____ _____ _____ _____ _____

Did you have any contact with blood or body fluids? ☐ **Yes** ☐ **No**

Body fluid	What were you doing?	Was this protected (PPE)?	What PPE did you typically wear?	Did you have visible soilage of PPE?	Areas of contact (pick all that apply)?
Blood # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____
Respiratory # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____
Stool # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____

ID _____ _____ _____ _____ _____

Body fluid	What were you doing?	Was this protected (PPE)?	What PPE did you typically wear?	Did you have visible soilage of PPE?	Areas of contact (pick all that apply)?
Urine # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____
Vomitus # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____
Tears # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____

ID _____ _____ _____ _____ _____

Body fluid	What were you doing?	Was this protected (PPE)?	What PPE did you typically wear?	Did you have visible soilage of PPE?	Areas of contact (pick all that apply)?
Sweat # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____
Other (Please specify) _____ # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____
Other (Please specify) _____ # times	☐ Phlebotomy ☐ Procedure ☐ Equipment ☐ Soiled linen ☐ Contaminated surface ☐ Biohazard waste ☐ Cleaning ☐ Other (please specify)_____	☐ Yes ☐ No	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify):_____	☐ Yes ☐ No	☐Protected Not protected ☐ Intact skin ☐ Broken skin ☐ Mucous membranes (please specify)_____ ☐ Percutaneous exposure ☐ Other (please specify_____

Were you involved with any procedures (either performing or in room)?		
Intubation	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Central line placement	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Bronchoscopy	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
CPR	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Sputum induction	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Extubation	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Airway suctioning	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Nasogastric tube placement	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Nebulizer treatment	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Dialysis	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Rectal tube placement or manipulation	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Arterial line placement	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Peripheral IV placement	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Noninvasive ventilation	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____
Lumbar puncture	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____

Other (please specify) _____	☐ Performed or assisted with procedure ☐ Present in room	☐ Face shield ☐ Goggles ☐ Facemask ☐ Respirator/N95 ☐ Gloves ☐ Gown ☐ Other (please specify): _____

Did you come into contact with body following death? Yes No

Did you have any other contact with the patient not previously mentioned?

Section 4: PPE training----------

Have you received training on proper selection of PPE for standard precautions? ☐ Yes ☐ No

Have you received training on how to don:

- Gloves? ☐ Yes ☐ No
- Gown? ☐ Yes ☐ No
- Eye protection? ☐ Yes ☐ No

Have you received training on how to doff (so as not to contaminate):

- Gloves? ☐ Yes ☐ No
- Gown? ☐ Yes ☐ No
- Eye protection? ☐ Yes ☐ No

How often does this training occur? _____

When did you last receive training? _____

Were you required to demonstrate competency? ☐ Yes ☐ No

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

Hepatitis A: Supplemental Case Questionnaire

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Section 1: <u>Interviewer information</u> *(Questions 1-3 to be completed by interviewer prior to questionnaire administration)*

1. Date of Interview: __ __ / __ __ / __ __ __ __ *(if unknown, enter 99/99/9999)*
   M M D D Y Y Y Y
2. Interviewer Information:
   a. Name: _____
   b. Contact phone number: (____) _____-_____
   c. Agency or Organization: _____
3. Respondent was: ☐Self ☐Parent ☐Spouse ☐Other (Specify):_____

MAVEN ID: __ __ __ __ __ __ __ __ __

Section 2: <u>Food Recall</u>

1. **In the period 15 to 50 days before you became ill, did you eat at a Sushi Restaurant A location in Hawaii?**

(This date must be on or before August 15, 2016. If a later date is provided, ask about dates on or before August 15.)

☐ Yes ☐ No ☐ Unknown

*****If No or Unknown, proceed to QUESTION #7*

2. **If yes, at which Sushi Restaurant A location or locations did you eat? (ask each location)**

☐ Aina Hana, Honolulu
☐ Ala Moana Center, Honolulu
☐ Ewa Town Center, Ewa
☐ Kaneohe, Kaneohe
☐ Kapahulu, Honolulu
☐ Kapolei Commons, Kapolei
☐ Pearlridge Center, Uptown
☐ Waikele Center, Waipahu
☐ Waiau, Pearl City
☐ Ward Center, Honolulu
☐ Kukui Grove Shopping Center, Lihue

☐ Other *(write in location)* _____
☐ Don't know
☐ Refused

3. **What were the date(s) of your most recent visit(s) to Sushi Restaurant A within this period?**

4. **Did you eat raw or undercooked fish or seafood while at Sushi Restaurant A during this period?**

☐ Yes ☐ No ☐ Unknown

5. **If yes, did you eat scallops?**

☐ Yes ☐ No ☐ Unknown

6. **Did you eat scallops anywhere besides Sushi Restaurant A in the 15 to 50 days before becoming ill?**

☐ Yes ☐ No ☐ Unknown

*****If No or Unknown, proceed to QUESTION #9*

7. **Were the scallops raw or undercooked?**

☐ Yes ☐ No ☐ Unknown

8. **Where did the scallops come from?** *(Please specify restaurant/store name and location)*

_____ ☐ Unknown

9. **Did you eat at a potluck in the 15 to 50 days before becoming ill?**

☐ Yes ☐ No ☐ Unknown

*****If No or Unknown, proceed to End of Survey Instructions.*

10. **Did you eat raw or undercooked fish or seafood at the potluck?**

☐ Yes ☐ No ☐ Unknown

*****If No or Unknown, proceed to End of Survey Instructions.*

11. **Did you eat scallops at the potluck?**

☐ Yes ☐ No ☐ Unknown

****If No or Unknown, proceed to End of Survey Instructions.*

12. Were these scallops raw or undercooked?

☐ Yes ☐ No ☐ Unknown

13. Where did the potluck scallops come from? *(Please specify restaurant/store name and location)*

_____ ☐ Unknown

Notes from call:

Data Entry By: _____

Form Approved
OMB No. 0920-1101
Exp. Date 03/31/2017

CASE INTERVIEW FORM

CDC ID: ☐☐☐☐ **Date:** ☐☐/☐☐/2016 **Data collector initials:** _____

1. Last Name_____ First Name_____
2. **Unit:**
3. **Room:**
4. **DOB:** ☐☐/☐☐/☐☐☐☐

Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

CDC ID: ☐☐☐☐

Foodborne disease outbreak questionnaire

Part I. Demographics:

1. Age: _____ Sex_____(M/F)	2. Race (check all that apply) ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Native Hawaiian/other Pacific Islander ☐Unknown ☐Other race	3. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

4. When were you admitted to this detention center? Date: ____ / ____ / ____ (MM/DD/YY)

5. Do you help in the kitchen? Yes / No

6. Do you help serve the food on the food cart? Yes / No

CDC ID: ☐☐☐☐

Part II. Clinical information: We're going to ask you some questions about your symptoms when you got sick.

7. Have you had any symptoms of gastrointestinal illness during the week of July 10th, 2016? Yes / No
8. What day did your symptoms begin: _____ / ____ / ____ / 2016 (example: Tuesday MM/DD)
9. *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

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

Symptom	Yes/ No/Unknown	Onset Date	Resolution date	Notes
Nausea	☐Yes ☐No ☐Unk	___/____/2016	////////////////////////////////	
Vomiting	☐Yes ☐No ☐Unk	___/____/2016	___/____/2016	If yes, what is the largest number of episodes you had in a 24 hour period ? _____
Diarrhea	☐Yes ☐No ☐Unk	___/____/2016	___/____/2016	If yes, what is the largest number of episodes you had in a 24 hour period ? _____ Did you provide a stool sample? ☐Yes ☐No
Bloody Diarrhea	☐Yes ☐No ☐Unk	___/____/2016	////////////////////////////////	If yes, what is the largest number of episodes you had in a 24 hour period ? _____
Fever	☐Yes ☐No ☐Unk	___/____/2016	___/____/2016	Highest temperature, if measured _____☐°C or ☐°F
Headache	☐Yes ☐No ☐Unk	___/____/2016	////////////////////////////////	
Abdominal pain/cramping	☐Yes ☐No ☐Unk	___/____/2016	////////////////////////////////	
Other:_____		___/____/2016	////////////////////////////////	

11. Did you seek medical care at the medical unit? Yes / No
    a. When? Date____ / ____ / 2016 Time____:____ AM/ PM
12. Did you receive any medications? Yes / No
13. If yes, specify: _____
14. Were any of your cube/room/bunk mates vomiting or having diarrhea during those days? Yes / No

Part III. Food: Now we are going to ask your some questions about the foods that you ate on July 9 through July 12. We know that it may be difficult to remember what you ate a month ago, but please try to answer these questions as best as you can.

15. Did you eat food from the food cart on Saturday, July 9? Yes / No

16. Did you eat a special meal on Saturday, July 9? Yes / No

17. If yes, specify:_____

18. Did you eat food from the food cart on Sunday, July 10? Yes / No

19. Did you eat a special meal on Sunday, July 10? Yes / No

20. If yes, specify:_____

21. Did you eat food from the food cart on Monday, July 11? Yes / No

22. Did you eat a special meal on Monday, July 11? Yes / No

23. If yes, specify:_____

24. Did you eat food from the food cart on Tuesday, July 12? Yes / No

25. Did you eat a special meal on Tuesday, July 12? Yes / No

26. If yes, specify:_____

27. Please place an X next to any food item the inmate ate on any of these days:

CDC ID: ☐☐☐☐

Saturday, July 9		**Sunday, July 10**		**Monday, July 11**		**Tuesday, July 12**	
Breakfast		**Breakfast**		**Breakfast**		**Breakfast**	
Grits		Oatmeal		Grits		Fruit Drink	
Breakfast Sausage		Scrambled Egg		Biscuit		Oatmeal	
Pancake Square		Oven Brown Potatoes		Sausage		Scrambled Eggs	
Margarine		Biscuit		Gravy		O'Brien potatoes	
Maple Syrup		Margarine		Lyonnaise Potatoes		Biscuit	
Dairy Drink		Jelly		Margarine		Margarine	
		Dairy Drink		Dairy Drink		Jelly	
						Dairy Drink	
Lunch		**Lunch**		**Lunch**		**Lunch**	
Cheese Slice		Ham		Turkey Bologna		Cheese Slice	
Turkey Salami		Lettuce/Cabbage Salad		Creamy Cole Slaw		Turkey Salami	
Pasta Salad		Bread		Bread		Marinated Vegetable Salad	
Bread		Mustard		Mustard		Bread	
Mustard		Salad Dressing		Cookie Square		Mustard	
Cookie Square		Cookie square		Fruit Drink		Cookie Square	
Fruit Drink		Fruit Drink				Fruit Drink	
Dinner		**Dinner**		**Dinner**		**Dinner**	
Roast Turkey		Chicken Patty		Italian Meat Sauce		Chili Con Carne	
Poultry Gravy		Rice Pilaf		Spaghetti Noodles		Plain rice	
Mashed Potatoes		Seasoned Carrots		Seasoned Green Beans		Seasoned Cabbage	
Seasoned Mixed Vegetables		Cornbread		Garlic Bread		Cornbread	
Cornbread		Margarine		Dessert Bar		Margarine	
Margarine		Brownie		Sweat tea		Sweet Tea	
Frosted cake		Sweet Tea					
Sweet Tea							

28. Do you purchase food from the canteen? Yes / No **CDC ID:** ☐☐☐☐

If yes, please indicate which foods you ate on July 9 through July 12.	
Jalapeno cheese packets	
Honey bun glazed	
Honey bun iced	
Jalapeno pretzel pieces	
Dill pickle	
Hot pickle	
Beef & cheese stick	
Hickory beef stick	
BF summer sausage	
Hot sausage	
Hot BF summer sausage	
Tuna in pouch	
Mayonnaise packet	
BBQ sauce 1.25oz	
Peanut butter pkt	
Ranch dressing 1.5oz	
Grape jelly pkt	
Chex mix	
Trail mix	
Salted peanuts	
Strawberry cheese claw	
Cinnamon roll	
Chocolate cupcakes	
Banana pudding cupcake	
Donut sticks	
Instant grits 12CT	
Oatmeal pkts	
Nutty bar	
Oatmeal cream pie	
Brownie	
Pop-tarts – Strawberry	
Granola bar	
Peanut butter crème	
Duplex crème	
Strawberry crème	
Chocolate crème cookies	
Toastchee	
Jalapeno cheddar cracker	
Grill cheese cracker	
Saltine crackers	
S.F. wafers – vanilla	
S.F wafers – chocolate	
Cheetos	
Krispie treat	
Chocolate moon pie	
Snack crackers	
Banana moon pie	
Chocolate chip cookies	
Salt & vinegar chips 1oz	
Jalapeno cheese puffs 1oz	
BBQ chips	
Plain chips	
BBQ corn chips	
Nacho cheese chips	
Cheddar & sour cream (chips) 1oz	
Buffalo chips	
Voodoo chips	
BBQ pork skins	
Cheez-its	
White cheddar popcorn	
Cheese curls – 10oz	
Spicy hot chips 5.5oz	
Ridged potato chips 5.5oz	
GF 5.5oz BBQ chips	
Salsa verde tortilla chips	
Sour cream & onion chips 5.5oz	
Chicken cup-a-soup	
Shrimp cup-a-soup	
Beef cup-a-soup	
Chili soup	
Beef soup	
Lime chili shrimp soup	
Chicken soup	
Cajun chicken soup	
Oriental soup	
Spam (pouch)	
Mackerel fillet – 3.53oz	
Flour tortilla	
Sardines n hot sauce	
Loaded mashed potatoes	
Chicken breast – 3oz	
Sweet & salty nut mix 2oz	
Iced oatmeal cookies	

CDC ID: ☐☐☐☐

Now, I will ask you more questions about what you ate and drank during July 9-12th. Try to remember and answer as best as you can.

29. Was any of the food you ate undercooked? Yes / No / Don't Know
30. If yes, Specify: _____

31. Did you eat any food that was not provided on the food cart or in the canteen? Yes / No
32. Specify: _____

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

35. Did you drink any beverages that were not provided on the food cart or in the canteen? Yes / No
36. Specify: _____

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

39. Did you eat any leftover food from the food cart from previous days? Yes / No
40. If yes, Specify: _____

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

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

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

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

48. Are there any foods that you refuse to eat here? **Yes / No**
49. If yes, specify: _____

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

Part IV. Handwashing Practices

51. Do you typically wash your hands? Yes / No
52. How many times per day do you usually wash your hands? _____
53. Can you tell me when you wash your hands? *(keep prompting for additional responses)*

    _____

    _____

54. Do you have your own soap? Yes / No

55. Do you use soap every time you wash your hands? Yes / No

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

_____

_____

_____

_____

Form Approved
OMB No. 0920-1101
Exp. Date 03/31/2017

CASE INTERVIEW FORM

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

1. Last Name_____ First Name_____

2. **Unit:**

3. **Room:**

4. **DOB:** ☐☐/☐☐/☐☐☐☐

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

CDC ID _____

Foodborne disease outbreak questionnaire

Screening question for controls

Between Saturday, July 9th and Tuesday, July 19th, did you experience any vomiting or diarrhea, which we define as three or more loose stools in a 24 hour period?

YES / NO

If, yes: Thank you for participating. That is the only information that we need to collect.

If no: Thank you. Now we would like to collect some background information.

Part I. Demographics:

1. Age: _____ Sex_____(M/F)	2. Race (check all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian/other Pacific Islander ☐ Unknown ☐ Other race	3. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

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

5. Do you help in the kitchen? Yes / No

6. Do you help serve the food on the food cart? Yes / No

Part II. Illnesses

14. Were any of your cube/room/bunk mates vomiting or having diarrhea during the week of July 10th? Yes / No

CDC ID _____

Part III. Food: Now we are going to ask your some questions about the foods that you ate on July 9 through July 12. We know that it may be difficult to remember what you ate a month ago, but please try to answer these questions as best as you can.

7. Did you eat food from the food cart on Saturday, July 9? Yes / No
8. Did you eat a special meal on Saturday, July 9? Yes / No
9. If yes, specify:_____
10. Did you eat food from the food cart on Sunday, July 10? Yes / No
11. Did you eat a special meal on Sunday, July 10? Yes / No
12. If yes, specify:_____
13. Did you eat food from the food cart on Monday, July 11? Yes / No
14. Did you eat a special meal on Monday, July 11? Yes / No
15. If yes, specify:_____
16. Did you eat food from the food cart on Tuesday, July 12? Yes / No
17. Did you eat a special meal on Tuesday, July 12? Yes / No
18. If yes, specify:_____

CDC ID _____

19. Please place an X next to any food item the inmate ate on any of these days:

Saturday, July 9		**Sunday, July 10**		**Monday, July 11**		**Tuesday, July 12**	
Breakfast		**Breakfast**		**Breakfast**		**Breakfast**	
Grits		Oatmeal		Grits		Fruit Drink	
Breakfast Sausage		Scrambled Egg		Biscuit		Oatmeal	
Pancake Square		Oven Brown Potatoes		Sausage		Scrambled Eggs	
Margarine		Biscuit		Gravy		O'Brien potatoes	
Maple Syrup		Margarine		Lyonnaise Potatoes		Biscuit	
Dairy Drink		Jelly		Margarine		Margarine	
		Dairy Drink		Dairy Drink		Jelly	
						Dairy Drink	
Lunch		**Lunch**		**Lunch**		**Lunch**	
Cheese Slice		Ham		Turkey Bologna		Cheese Slice	
Turkey Salami		Lettuce/Cabbage Salad		Creamy Cole Slaw		Turkey Salami	
Pasta Salad		Bread		Bread		Marinated Vegetable Salad	
Bread		Mustard		Mustard		Bread	
Mustard		Salad Dressing		Cookie Square		Mustard	
Cookie Square		Cookie square		Fruit Drink		Cookie Square	
Fruit Drink		Fruit Drink				Fruit Drink	
Dinner		**Dinner**		**Dinner**		**Dinner**	
Roast Turkey		Chicken Patty		Italian Meat Sauce		Chili Con Carne	
Poultry Gravy		Rice Pilaf		Spaghetti Noodles		Plain rice	
Mashed Potatoes		Seasoned Carrots		Seasoned Green Beans		Seasoned Cabbage	
Seasoned Mixed Vegetables		Cornbread		Garlic Bread		Cornbread	
Cornbread		Margarine		Dessert Bar		Margarine	
Margarine		Brownie		Sweat tea		Sweet Tea	
Frosted cake		Sweet Tea					
Sweet Tea							

Now, I will ask you more questions about what you ate and drank during July 9-12th. Try to remember and answer as best as you can.

20. Was any of the food you ate undercooked? Yes / No / Don't Know
21. If yes, Specify: _____

22. Did you eat any food that was not provided on the food cart or in the canteen? Yes / No
23. Specify: _____

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

26. Did you drink any beverages that were not provided on the food cart or in the canteen? Yes / No
27. Specify: _____

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

30. Did you eat any leftover food from the food cart from previous days? Yes / No
31. If yes, Specify: _____

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

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

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

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

39. Are there any foods that you refuse to eat here? **Yes / No**
40. If yes, specify: _____

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

Part IV. Handwashing Practices

42. Do you typically wash your hands? Yes / No
43. How many times per day do you usually wash your hands? _____
44. Can you tell me when you wash your hands? *(keep prompting for additional responses)*

    _____

    _____

45. Do you have your own soap? Yes / No

46. Do you use soap every time you wash your hands? Yes / No

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

_____

_____

_____

_____

_____

_____