

Individual: sociodemographic characteristics and clinical history

Interviewer name: _____ Group number _____

Interview date: MM / DD / YYYY

Participant number (HHID P PID): X X # # # # P # #

Eligibility criteria and consent

Sleeps in this house **4+ nights/week**

Yes

Does not have definite plans to move (6 mo)

Yes

Age: _____ years

1-50

Emancipated

minor:

Lives independently from parents

Married

Has children

Consent (individuals 21+, parents of minors 1-20)

- Written consent completed.
- Agree to do the questionnaire.
- Agree to give a blood sample.
- Agree to the use of blood sample for future studies.
- Agree to be contacted periodically in relation to this study.

Assent (minors only: verbal 7-11, written 12-20)

- Written consent completed (12-20).
- Verbal consent completed (7-11).
- Agree to do the questionnaire.
- Agree to give a blood sample.
- Agree to the storage of blood sample for use in future studies.
- Agree to be contacted periodically in relation to this study.

Name:

Paternal Last Name Maternal Last Name First Name Initial

Sex: Male Female Other

Date of birth: MM / DD / YYYY

Cell phone: Preferred method(s) of contact: _____

Text message: _____

Individual: sociodemographic characteristics and clinical history

D1. What is the highest level of education that you have obtained?

- No school
- Grades 1 to 5
- Grades 6 to 8
- Grades 9 to 11
- Completed grade 12/GED
- Technical or associate's degree
- Bachelor's degree
- Professional degree
- Post-graduate study

D2. What is your current employment status?

Probe if necessary.

- Part-time employee
- Full-time employee
- Business owner
- Casual or Informal work
- Student
- Student and working
- Retired
- Unemployed
- Unable to work due to health problems
- Homemaker
- Other: _____

D3. Which of the following best describes your place of work?

- Primarily indoor work
- Primarily outdoor work
- Travel between different buildings or places of work
- Mostly in a car
- Variable
- Other: _____

D4. Do you currently have medical insurance?

Yes |

No

D4a. Type of insurance:

Read all options. Mark all that apply.

- Reforma/Plan Mi Salud
- Medicare
- Medicaid
- Private
- Tricare
- Other: _____

D5. How long have you been living in this community?

- House phone: _____
- Work phone: _____
- Other phone: _____
- Email: _____
- Mail _____
- Use Household Representative information

CLINICAL HISTORY Now I will ask you some questions about your medical history.

C1_0. Have you participated in any **research study** in which you received a vaccine for **Zika** or **dengue**?

- Zika | Dengue |

No _____ Females only: _____

C1_1. Are you **pregnant**? Yes |

No C1_2. How many **weeks** pregnant are you? _____

C2_0. Do you have a fever **currently** or in the **last 7 days**? Yes |

No

C2_1. Date that the fever **began**: ___/___/___
MM DD YYYY

C2_2. Have you had any of the following **symptoms**?

Read all the options. Mark all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Light bleeding |
| <input type="checkbox"/> Abdominal pain | (gums, nose, petechial, |
| <input type="checkbox"/> Joint pain | and/or bruising) |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Heavy bleeding |
| <input type="checkbox"/> Sore throat | (bloody vomit/cough/ stool, heavy vaginal |
| <input type="checkbox"/> Muscle pain | bleeding) |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Calf pain | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nausea/vomiting | |

C2_3. Did you see a **doctor** for these symptoms? Yes |

No

C2_4. Did the **doctor diagnose** you with any of the following illnesses?

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Dengue | <input type="checkbox"/> Viral syndrome |
| <input type="checkbox"/> Chikungunya | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Zika | <input type="checkbox"/> Other: _____ |

C2_5. Were you **hospitalized**? Yes |

No

C2_6. **How many days** were you hospitalized? _____ days

C2_7. In which **hospital**?

- | | |
|--|--|
| <input type="checkbox"/> San Lucas | <input type="checkbox"/> Concepción/ San Germán |
| <input type="checkbox"/> Damas | <input type="checkbox"/> Metropolitano/ San Germán |
| <input type="checkbox"/> San Cristóbal | <input type="checkbox"/> Pavía/Yauco |
| <input type="checkbox"/> Metropolitano/ Dr. Pila | <input type="checkbox"/> Otro: _____ |
| <input type="checkbox"/> Menonita/Guayama | |

C2_8. How many days of **work** did you miss for being sick? _____ days

C2_9. How many days of **school** did you miss for being sick? _____ days

(years)

D6. From **6am - 8pm**, (14 hrs) how much time do you spend in your house or in this community or urbanization?

- | | |
|------------------------|-----------------------|
| Monday: _____ hours | Friday: _____ hours |
| Tuesday: _____ hours | Saturday: _____ hours |
| Wednesday: _____ hours | Sunday: _____ hours |
| Thursday: _____ hours | |

C2_14. Approximately how much **money** did you spend during the illness, including doctor's visits, medications, and transportation costs? \$_____ Does not recall

C3_0. Have you had (another) fever in the **last 12 months**, since this month of the past year?

Yes | No

C3_1. Date that the fever **began**: ___/___/___
MM DD YYYY

C3_2. Did you have any of the following **symptoms**?

Read all the options. Mark all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Light bleeding |
| <input type="checkbox"/> Abdominal pain | (gums, nose, petechial, |
| <input type="checkbox"/> Joint pain | and/or bruising) |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Heavy bleeding |
| <input type="checkbox"/> Sore throat | (bloody vomit/cough/ stool, heavy vaginal |
| <input type="checkbox"/> Muscle pain | bleeding) |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Calf pain | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nausea/vomiting | |

C3_3. Did you see a **doctor** for these symptoms? Yes |

No

C3_4. Did the **doctor diagnose** you with any of the following illnesses

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Dengue | <input type="checkbox"/> Viral syndrome |
| <input type="checkbox"/> Chikungunya | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Zika | <input type="checkbox"/> Other: _____ |

C3_5. Were you **hospitalized**? Yes |

No

C3_6. **How many days** were you hospitalized? _____ days

C3_7. In which **hospital**?

- | | |
|--|--|
| <input type="checkbox"/> San Lucas | <input type="checkbox"/> Concepción/ San Germán |
| <input type="checkbox"/> Damas | <input type="checkbox"/> Metropolitano/ San Germán |
| <input type="checkbox"/> San Cristóbal | <input type="checkbox"/> Pavía/Yauco |
| <input type="checkbox"/> Metropolitano/ Dr. Pila | <input type="checkbox"/> Otro: _____ |
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C3_8. How many days of **work** did you miss for being sick? _____ days

C3_9. How many days of **school** did you miss for being sick? _____ days

C3_10. Did someone else have to miss **work** to help

C2_10. Did someone else have to miss **work** to help you while you were sick?

If multiple people took care of the participant,

Yes |

No

add all the days missed together.

C2_11. How many days of **work** did they miss? _____

C2_12. Did someone else have to miss **school** to help you while you were sick?

Add all the days missed together.

Yes |

No

C2_13. How many days of **school** did they miss? _____

you while you were sick?

If multiple people took care of the participant,

Yes |

No

add all the days missed together.

C3_11. How many days of **work** did they miss? _____

C3_12. Did someone else have to miss **school** to help you while you were sick?

Add all the days missed together.

Yes |

No

C3_13. How many days of **school** did they miss? _____

C3_14. Approximately how much **money** did you spend during the illness, including doctor's visits, medications, and transportation costs? \$ _____

Does not recall
