

Patient Screening Questionnaire

Answers are being provided on behalf of:

- Self
 Child

Please answer the questions to the best of your ability. It is ok to say you don't know.

1. Our records show that you (your child) was diagnosed with RMSF in _____(mm/yyyy). Is this correct?
 Yes / No / Don't know

--If no, please provide us with the approximate date in which you (your child) had RMSF:
 _____(mm/yyyy)

2. Our records also show that you (your child) left the hospital on _____(MM/DD/YYYY). Is this correct?
 Yes / No / Don't know

3. After you left the hospital, where did you (your child) go?

- Home Another hospital
 Nursing home Rehabilitation facility
 Other
 Don't remember

Name of facility: _____

How long were you there? _____

4. On a scale of 1 to 5 how would you rate your (your child's) overall ability to function before your RMSF illness?
 (Unable to function in my daily life) 1 — 2 — 3 — 4 — 5 (perfectly able to function)

5. Do you feel like you (your child) has recovered fully from your RMSF illness?

Yes / No / Don't know

--If yes:

how long did it take to get back to normal? _____

--If no:

have your (your child's) symptoms improved over time?

Yes / No / Don't know

what symptoms are you (your child) still experiencing? _____

--If don't know, proceed to next question.

6. On a scale of 1 to 5 how would you rate your (your child's) overall ability to function since your (their) RMSF illness?
 (Unable to function in my daily life) 1 — 2 — 3 — 4 — 5 (perfectly able to function)

7. Have you (your child) been diagnosed with neurologic illness since your (their) RMSF illness (such as a stroke, dementia, Parkinson's Disease, etc.)

Yes / No / Don't know

--If yes:

what was the illness? _____

when was it diagnosed? _____

8. Are there any activities which you (your child) used to do before your RMSF illness that you (they) are unable to do at this time?

Yes / No / Don't know

--If yes:

please list which activities:

do you think this change is due to your (their) RMSF illness?

Yes / No / Don't know

Neurologic Exam Form Final

Public reporting burden of this collection of information is estimated to average 40 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)

NEUROLOGIC EXAM FORM

Patient data (remove top page following exam)

Patient's Name: _____
Last Name First Name

PATIENT ID _____

Date of Birth: ____/____/____
MM DD YYYY

Gender: M F

Tribal community: _____

Tribal affiliation: _____

FINAL

NEUROLOGIC EXAM FORM

PATIENT ID _____

Date of RMSF onset: _____ / _____ / _____

MM DD YYYY

Age at illness (years): _____

Current age (years): _____

Neurologic exam completed?

Yes No

If yes,

Date of exam: _____ / _____ / _____

Provider performing exam: _____

If no, why not?

Deceased Lost to follow up Did not consent Other, describe: _____

I. Altered mental status

Altered Normal Unknown/Unable to determine

(If altered or unknown, proceed to II. Mental status examination, otherwise skip to III. Language)

II. Mental status (8 years and older) (as determined by the healthcare provider using the Montreal Cognitive Assessment (MOCA)) (If less than 8 years skip to section IV, cranial nerve assessment.)

Visuospatial/executive: _____ (5) Attention: _____ (6) Abstraction: _____ (2) Orientation _____ (6)

Naming: _____ (3) Language: _____ (3) Delayed recall _____ (5) **TOTAL: _____ (30)**

III. Language (8 years and older)

Normal Expressive aphasia Receptive aphasia Global aphasia Dysarthria

Description of difficulty: _____

IV. Cranial nerves

CN I Normal Abnormal, describe: _____

CN VI Normal Abnormal, describe: _____

CN II

Pupil exam Normal Abnormal, describe: _____

CN VII Normal Abnormal, describe: _____

Accommodation Normal Abnormal, describe: _____

CN VIII Normal Abnormal, describe: _____

Visual field Normal Abnormal, describe: _____

CN IX Normal Abnormal, describe: _____

Visual acuity Normal Abnormal, describe: _____

CN X Normal Abnormal, describe: _____

Fundoscopic exam Normal Abnormal, describe: _____

CN XI Normal Abnormal, describe: _____

CN III Normal Abnormal, describe: _____

CN XII Normal Abnormal, describe: _____

CN IV Normal Abnormal, describe: _____

CN V Normal Abnormal, describe: _____

V. Sensory

Upper extremities Normal Numbness Paresthesias Other, describe: _____

Lower extremities Normal Numbness Paresthesias Other, describe: _____

Core Normal Numbness Paresthesias Other, describe: _____

Face Normal Numbness Paresthesias Other, describe: _____

VI. Motor

A. Abnormal movements

Fasciculations Yes No Comments: _____

Tremor Yes No Comments: _____

Chorea/dyskinesias Yes No Comments: _____

Myoclonus Yes No Comments: _____

B. Bulk

Atrophy Yes No Comments: _____

C. Tone

Upper extremities Normal Increased (spastic or rigid) Decreased Comments: _____

Lower extremities Normal Increased (spastic or rigid) Decreased Comments: _____

Core Normal Increased (spastic or rigid) Decreased Comments: _____

D. Other upper motor neuro signs

Pronator drift Yes No Yes No Comments: _____

Finger tap speed Normal Slow Normal Slow Comments: _____

Foot tap speed Normal Slow Normal Slow Comments: _____

NEUROLOGIC EXAM FORM

PATIENT ID _____

E. Strength (0 = No movement; 1 = Barely discernable movement; 2 = Movement along plane of gravity; 3 = Movement against gravity; 4 = Movement against resistance; 5 = Normal)

Neck flexors _____

Neck extensors _____

Upper extremity:

	R	L
	Deltoids	
	Biceps	
	Triceps	
	Wrist extensors	
	Wrist flexors	
	Finger extensors	
	Finger flexors	
	Abductor pollicis brevis	
	Opponens pollicis	
	Interossei	

Lower extremity:

	R	L
	Hip flexors	
	Hip extensors	
	Hip abduction	
	Hip adduction	
	Quadriceps	
	Hamstrings	
	Plantarflexors	
	Dorsiflexors	
	Foot evertors	
	Foot invertors	
	Extensor hallucis longus	
	Toe flexors	
	Toe extensors	

VII. Reflexes (0 = Absent; 1 = Decreased; 2 = Normal; 3 = Increased/hyperactive; 4 = sustained clonus)

	R	L
	Brachioradialis	
	Biceps	
	Triceps	
	Patellar	
	Ankle jerk	

Excessive jaw jerk Yes No

Sustained ankle clonus Yes No | Yes No

Plantar response (Babinski) Up Down Unclear | Up Down Unclear

VIII. Coordination

	R	L	Comments:
Finger-to-nose	<input type="checkbox"/> Normal <input type="checkbox"/> Dysmetric <input type="checkbox"/> Other	<input type="checkbox"/> Normal <input type="checkbox"/> Dysmetric <input type="checkbox"/> Other	_____
Heel-knee-shin	<input type="checkbox"/> Normal <input type="checkbox"/> Dysmetric <input type="checkbox"/> Other	<input type="checkbox"/> Normal <input type="checkbox"/> Dysmetric <input type="checkbox"/> Other	_____
Past-pointing	<input type="checkbox"/> Normal <input type="checkbox"/> Overshoot <input type="checkbox"/> Other	<input type="checkbox"/> Normal <input type="checkbox"/> Overshoot <input type="checkbox"/> Other	_____
Check reflex	<input type="checkbox"/> Normal <input type="checkbox"/> Loss of check reflex <input type="checkbox"/> Other	<input type="checkbox"/> Normal <input type="checkbox"/> Loss of check reflex <input type="checkbox"/> Other	_____

IX. Gait and station

- Spontaneous gait Normal Hemiplegic Steppage Shuffling Other, describe: _____
- Able to walk on toes Yes No
- Able to walk on heels Yes No
- Able to tandem Yes No
- Romberg Positive Negative Unable to assess

X. Additional narrative/comments:

Modified Rankin Scale (Determined by healthcare provider at exam)
Use pediatric modified Rankin for children less than 8 years of age (appendix A)

- 0 = No symptoms at all
- 1 = No significant disability despite symptoms; able to carry out all usual duties and activities
- 2 = Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
- 3 = Moderate disability; requiring some help, but able to walk without assistance
- 4 = Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
- 5 = Severe disability; bedridden, incontinent and requiring constant nursing care and attention
- 6 = Dead

SCORE (0 - 6): _____

Appendix A: Modified Rankin Scale for children

Score	Description
0	No symptoms at all
1	No significant disabilities despite symptoms in clinical examination; age appropriate behaviour and further development
2	Slight disability; unable to carry out all previous activities, but same independence as other age- and sex-matched children (no reduction of levels on the gross motor function scale)
3	Moderate disability; requiring some help, but able to walk without assistance; in younger patients adequate motor development despite mild functional impairment (reduction of one level on the gross motor function scale)
4	Moderately severe disability; unable to walk without assistance; in younger patients reduction of at least 2 levels on the gross motor function scale
5	Severe disability; bedridden, requiring constant nursing care and attention
6	Dead

Appendix 1: Questionnaire

Updated: August 28, 2018

Survey ID _____

Section 1: Questions about travel to Mexico and the southwest United States		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Did you attend a service trip to the Tijuana area of Mexico at any time during July 2018? <i>(Note that the Tijuana area is directly south of the San Diego metro area. For purposes of this survey, please consider nearby towns, including Rosarito and La Joya as part of the Tijuana area.)</i>
If Q1 is "No", END survey. Thank you for participating in the survey.		
2. When did you arrive in Mexico for this trip? <i>(If you don't know, check the box for "don't know" and record your best guess)</i> ___ / ___ / _____ <input type="checkbox"/> Don't know <i>MM DD YYYY</i>		
3. When did you leave Mexico at the end of this trip? <i>(If you don't know, check the box for "don't know" and record your best guess)</i> ___ / ___ / _____ <input type="checkbox"/> Don't know <i>MM DD YYYY</i>		
<input type="checkbox"/>	<input type="checkbox"/>	4. As part of this trip, did you travel anywhere else in Mexico before arriving in the Tijuana area?
→ SKIP if Q4 is No		5. <i>If yes, specify</i> _____
<input type="checkbox"/>	<input type="checkbox"/>	6. As part of this trip, did you travel anywhere else in Mexico after leaving the Tijuana area?
→ SKIP if Q6 is No		7. <i>If yes, specify</i> _____
<input type="checkbox"/>	<input type="checkbox"/>	8. As part of this trip, did you spend time in California or Arizona? <i>(Please don't count travel directly between the San Diego airport and the Mexico border)</i>
→ SKIP if Q8 is No		9. <i>If yes, specify location(s)</i> _____ 10. <i>Specify amount of time</i> _____
<input type="checkbox"/>	<input type="checkbox"/>	Don't Know <input type="checkbox"/>
→ SKIP if Q11 is No or don't know		11. Before this service trip, had you previously traveled to the Tijuana area or other parts of northwestern Mexico (i.e., the states of Baja California and Sonora)? 12. <i>If yes, in which years? Specify</i> _____ <i>(If you don't remember exactly, please use your best guess)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Don't Know <input type="checkbox"/>
→ SKIP if Q13 is No or don't know		13. Before this service trip, had you previously traveled to southern California or Arizona? 14. <i>If yes, in which years? Specify</i> _____ <i>(If you don't remember exactly, please use your best guess)</i>

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Section 2: Questions about your activities during travel to Mexico

Yes	No	Don't Know				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Did you help build houses during the 2018 service trip?			
16. How many houses did you work on during this trip?						
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more						
<i>We would like to know which houses you worked on and what type of soil-related activities you did each day of your trip. We have provided pictures of the houses along with their location names to help you identify them as best you can. Please answer as best you can remember, even if you're not sure.</i>						
<i>House A (Castores) Next to a school, and view of a valley at the end of the street.</i>						
<i>House B (Rosarito) Urban nice neighborhood.</i>						
<i>House C (Cumbres) Top of a hill with breezy ocean view.</i>						
17. On Monday , which house did you work at?						
<input type="checkbox"/> House A <input type="checkbox"/> House B <input type="checkbox"/> House C <input type="checkbox"/> Other. Specify _____ (describe the house the best you can such as how far it was from the Posada, whether it was paved road, whether it was rural or urban location, whether it was next to a school, whether there were many stray dogs, and whether you saw a valley or an ocean)						
As best you can recall, did you do the following activity?			Yes	No	Don't Know	For about how many hours total?
18. Digging trenches or holes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. _____ hours
20. Shoveling or wheelbarrowing dirt/soil			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. _____ hours
22. Mixing/making cement from dry ingredients (sand and gravel)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. _____ hours
24. Filling or passing buckets with sand or soil			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. _____ hours
26. Filling or passing buckets with cement			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. _____ hours
28. Passing empty buckets			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. _____ hours
30. Backfilling the trench (putting dirt back into the foundation of the house)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. _____ hours
32. Compacting dirt/soil in the trench			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. _____ hours
34. Cutting and bending rebar			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. _____ hours
36. Tying rebar for the floor or the roof			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. _____ hours
38. Laying blocks in the trench to make walls			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. _____ hours
40. Building the roof			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. _____ hours
42. Other activities, <i>specify</i> _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. _____ hours
44. Other activities, <i>specify</i> _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. _____ hours
46. Did you use any of the following tools this day? (check all that apply)						
<input type="checkbox"/> Shovel <input type="checkbox"/> Pick <input type="checkbox"/> Electric tamper/soil compactor <input type="checkbox"/> Manual tamper/soil compactor <input type="checkbox"/> Wheelbarrow <input type="checkbox"/> Other, <i>specify</i> _____						
47. How much of the time while you were working on the house this day was there dust in the air you were breathing?						
<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Don't know						

48. During times when you could see dust in the air, did you wear any type of covering over your mouth and nose at any time this day? <input type="checkbox"/> No <input type="checkbox"/> Bandanna <input type="checkbox"/> Dust mask <input type="checkbox"/> Respirator (e.g., N-95) <input type="checkbox"/> Other, specify _____			
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. Did you notice dust on your clothes at the end of this day?
→ Skip if Q49 is No or Don't know		50. If yes, how dusty was your clothes? <input type="checkbox"/> Extremely dusty <input type="checkbox"/> Very dusty <input type="checkbox"/> Mildly dusty <input type="checkbox"/> Just a little bit of dust	
→ Skip if Q49 is No or Don't know		51. As best as you can recall, what was the color of the dust? <input type="checkbox"/> Black <input type="checkbox"/> Tan brown <input type="checkbox"/> Mustard yellow <input type="checkbox"/> Other. Specify _____	
→ Skip if Q49 is No or Don't know		52. Where did you shake off your dusty clothes at the end of the day? Specify _____	
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. Were you near someone moving or digging dirt?
→ Skip if Q53 is No or Don't know		54. If yes, what do you consider near? Specify _____ feet	
55. On Tuesday , which house did you work at? <input type="checkbox"/> House A <input type="checkbox"/> House B <input type="checkbox"/> House C <input type="checkbox"/> Other. Specify _____ (describe the house the best you can such as how far it was from the Posada, whether it was paved road, whether it was rural or urban location, whether it was next to a school, whether there were many stray dogs, and whether you saw a valley or an ocean)			
As best you can recall, did you do the following activity?		Yes	No
		Don't Know	For about how many hours total?
56. Digging trenches or holes		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	57. _____ hours
58. Shoveling or wheelbarrowing dirt/soil		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	59. _____ hours
60. Mixing/making cement from dry ingredients (sand and gravel)		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	61. _____ hours
62. Filling or passing buckets with sand or soil		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	63. _____ hours
64. Filling or passing buckets with cement		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	65. _____ hours
66. Passing empty buckets		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	67. _____ hours
68. Backfilling the trench (putting dirt back into the foundation of the house)		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	69. _____ hours
70. Compacting dirt/soil in the trench		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	71. _____ hours
72. Cutting and bending rebar		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	73. _____ hours
74. Tying rebar for the floor or the roof		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	75. _____ hours
76. Laying blocks in the trench to make walls		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	77. _____ hours
78. Building the roof		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	79. _____ hours
80. Other activities, specify _____		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	81. _____ hours
82. Other activities, specify _____		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	83. _____ hours
84. Did you use any of the following tools this day? (check all that apply) <input type="checkbox"/> Shovel <input type="checkbox"/> Pick <input type="checkbox"/> Electric tamper/soil compactor <input type="checkbox"/> Manual tamper/soil compactor <input type="checkbox"/> Wheelbarrow <input type="checkbox"/> Other, specify _____			

85. How much of the time while you were working on the house this day was there dust in the air you were breathing? <input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Don't know			
86. During times when you could see dust in the air, did you wear any type of covering over your mouth and nose at any time this day? <input type="checkbox"/> No <input type="checkbox"/> Bandanna <input type="checkbox"/> Dust mask <input type="checkbox"/> Respirator (e.g., N-95) <input type="checkbox"/> Other, specify _____			
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	87. Did you notice dust on your clothes at the end of this day?
→ Skip if Q87 is No or Don't know		88. If yes, how dusty was your clothes? <input type="checkbox"/> Extremely dusty <input type="checkbox"/> Very dusty <input type="checkbox"/> Mildly dusty <input type="checkbox"/> Just a little bit of dust	
→ Skip if Q87 is No or Don't know		89. As best as you can recall, what was the color of the dust? <input type="checkbox"/> Black <input type="checkbox"/> Tan brown <input type="checkbox"/> Mustard yellow <input type="checkbox"/> Other. Specify _____	
→ Skip if Q87 is No or Don't know		90. Where did you shake off your dusty clothes at the end of the day? Specify _____	
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	91. Were you near someone moving or digging dirt?
→ Skip if Q91 is No or Don't know		92. If yes, what do you consider near? Specify _____ feet	
93. On Wednesday , which house did you work at? <input type="checkbox"/> House A <input type="checkbox"/> House B <input type="checkbox"/> House C <input type="checkbox"/> Other. Specify _____ (describe the house the best you can such as how far it was from the Posada, whether it was paved road, whether it was rural or urban location, whether it was next to a school, whether there were many stray dogs, and whether you saw a valley or an ocean)			
As best you can recall, did you do the following activity?			For about how many hours total?
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	95. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	97. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	99. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	101. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	103. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	105. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	107. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	109. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	111. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	113. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	115. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	117. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	119. _____ hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	121. _____ hours

122. Did you use any of the following tools this day? (check all that apply) <input type="checkbox"/> Shovel <input type="checkbox"/> Pick <input type="checkbox"/> Electric tamper/soil compactor <input type="checkbox"/> Manual tamper/soil compactor <input type="checkbox"/> Wheelbarrow <input type="checkbox"/> Other, specify _____				
123. How much of the time while you were working on the house this day was there dust in the air you were breathing? <input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Don't know				
124. During times when you could see dust in the air, did you wear any type of covering over your mouth and nose at any time this day? <input type="checkbox"/> No <input type="checkbox"/> Bandanna <input type="checkbox"/> Dust mask <input type="checkbox"/> Respirator (e.g., N-95) <input type="checkbox"/> Other, specify _____				
Yes	No	Don't Know		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	125. Did you notice dust on your clothes at the end of this day? 126. If yes, how dusty was your clothes? <input type="checkbox"/> Extremely dusty <input type="checkbox"/> Very dusty <input type="checkbox"/> Mildly dusty <input type="checkbox"/> Just a little bit of dust	
→ Skip if Q125 is No or Don't know			127. As best as you can recall, what was the color of the dust? <input type="checkbox"/> Black <input type="checkbox"/> Tan brown <input type="checkbox"/> Mustard yellow <input type="checkbox"/> Other. Specify _____	
→ Skip if Q125 is No or Don't know			128. Where did you shake off your dusty clothes at the end of the day? Specify _____	
Yes	No	Don't Know		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	129. Were you near someone moving or digging dirt? 130. If yes, what do you consider near? Specify _____ feet	
→ Skip if Q129 is No or Don't know				
131. On Thursday , which house did you work at? <input type="checkbox"/> House A <input type="checkbox"/> House B <input type="checkbox"/> House C <input type="checkbox"/> Other. Specify _____ (describe the house the best you can such as how far it was from the Posada, whether it was paved road, whether it was rural or urban location, whether it was next to a school, whether there were many stray dogs, and whether you saw a valley or an ocean)				
As best you can recall, did you do the following activity?				
	Yes	No	Don't Know	For about how many hours total?
132. Digging trenches or holes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	133. _____ hours
134. Shoveling or wheelbarrowing dirt/soil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	135. _____ hours
136. Mixing/making cement from dry ingredients (sand and gravel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	137. _____ hours
138. Filling or passing buckets with sand or soil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	139. _____ hours
140. Filling or passing buckets with cement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	141. _____ hours
142. Passing empty buckets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	143. _____ hours
144. Backfilling the trench (putting dirt back into the foundation of the house)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	145. _____ hours
146. Compacting dirt/soil in the trench	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	147. _____ hours
148. Cutting and bending rebar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	149. _____ hours
150. Tying rebar for the floor or the roof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	151. _____ hours
152. Laying blocks in the trench to make walls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	153. _____ hours
154. Building the roof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	155. _____ hours

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156. Other activities, <i>specify</i> _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	157. _____ hours
158. Other activities, <i>specify</i> _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	159. _____ hours
160. Did you use any of the following tools this day? (check all that apply)						
<input type="checkbox"/> Shovel <input type="checkbox"/> Pick <input type="checkbox"/> Electric tamper/soil compactor <input type="checkbox"/> Manual tamper/soil compactor <input type="checkbox"/> Wheelbarrow <input type="checkbox"/> Other, <i>specify</i> _____						
161. How much of the time while you were working on the house this day was there dust in the air you were breathing?						
<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Don't know						
162. During times when you could see dust in the air, did you wear any type of covering over your mouth and nose at any time this day?						
<input type="checkbox"/> No <input type="checkbox"/> Bandanna <input type="checkbox"/> Dust mask <input type="checkbox"/> Respirator (e.g., N-95) <input type="checkbox"/> Other, <i>specify</i> _____						
Yes	No	Don't Know				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	163. Did you notice dust on your clothes at the end of this day?			
→ Skip if Q163 is No or Don't know			164. If yes, how dusty was your clothes?			
			<input type="checkbox"/> Extremely dusty <input type="checkbox"/> Very dusty <input type="checkbox"/> Mildly dusty <input type="checkbox"/> Just a little bit of dust			
→ Skip if Q163 is No or Don't know			165. As best as you can recall, what was the color of the dust?			
			<input type="checkbox"/> Black <input type="checkbox"/> Tan brown <input type="checkbox"/> Mustard yellow <input type="checkbox"/> Other. <i>Specify</i> _____			
→ Skip if Q163 is No or Don't know			166. Where did you shake off your dusty clothes at the end of the day?			
			<i>Specify</i> _____			
Yes	No	Don't Know				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	167. Were you near someone moving or digging dirt?			
→ Skip if Q167 is No or Don't know			168. If yes, what do you consider near? <i>Specify</i> _____ feet			
169. On Friday , which house did you work at?						
<input type="checkbox"/> House A <input type="checkbox"/> House B <input type="checkbox"/> House C <input type="checkbox"/> Other. <i>Specify</i> _____ (describe the house the best you can such as how far it was from the Posada, whether it was paved road, whether it was rural or urban location, whether it was next to a school, whether there were many stray dogs, and whether you saw a valley or an ocean)						
As best you can recall, did you do the following activity?			Yes	No	Don't Know	For about how many hours total?
170. Digging trenches or holes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	171. _____ hours
172. Shoveling or wheelbarrowing dirt/soil			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	173. _____ hours
174. Mixing/making cement from dry ingredients (sand and gravel)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	175. _____ hours
176. Filling or passing buckets with sand or soil			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	177. _____ hours
178. Filling or passing buckets with cement			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	179. _____ hours
180. Passing empty buckets			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	181. _____ hours
182. Backfilling the trench (putting dirt back into the foundation of the house)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	183. _____ hours
184. Compacting dirt/soil in the trench			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	185. _____ hours
186. Cutting and bending rebar			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	187. _____ hours
188. Tying rebar for the floor or the roof			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	189. _____ hours

190. Laying blocks in the trench to make walls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	191. _____ hours
192. Building the roof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	193. _____ hours
194. Other activities, <i>specify</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	195. _____ hours
196. Other activities, <i>specify</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	197. _____ hours
198. Did you use any of the following tools this day? (check all that apply)				
<input type="checkbox"/> Shovel <input type="checkbox"/> Pick <input type="checkbox"/> Electric tamper/soil compactor <input type="checkbox"/> Manual tamper/soil compactor <input type="checkbox"/> Wheelbarrow <input type="checkbox"/> Other, <i>specify</i> _____				
199. How much of the time while you were working on the house this day was there dust in the air you were breathing?				
<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Don't know				
200. During times when you could see dust in the air, did you wear any type of covering over your mouth and nose at any time this day?				
<input type="checkbox"/> No <input type="checkbox"/> Bandanna <input type="checkbox"/> Dust mask <input type="checkbox"/> Respirator (e.g., N-95) <input type="checkbox"/> Other, <i>specify</i> _____				
Yes	No	Don't Know		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	201. Did you notice dust on your clothes at the end of this day?	
→ Skip if Q201 is No or Don't know			202. If yes, how dusty was your clothes?	
			<input type="checkbox"/> Extremely dusty <input type="checkbox"/> Very dusty <input type="checkbox"/> Mildly dusty <input type="checkbox"/> Just a little bit of dust	
→ Skip if Q201 is No or Don't know			203. As best as you can recall, what was the color of the dust?	
			<input type="checkbox"/> Black <input type="checkbox"/> Tan brown <input type="checkbox"/> Mustard yellow <input type="checkbox"/> Other. <i>Specify</i> _____	
→ Skip if Q201 is No or Don't know			204. Where did you shake off your dusty clothes at the end of the day?	
			<i>Specify</i> _____	
Yes	No	Don't Know		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	205. Were you near someone moving or digging dirt?	
→ Skip if Q205 is No or Don't know			206. If yes, what do you consider near? <i>Specify</i> _____ feet	
Yes	No	Don't Know		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	207. Did you play volleyball at the Posada on this trip?	
→ Skip if Q207 is No			208. If yes, how many times did you play at the volleyball court?	
			<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> More than three times	
209. Please describe any other place that appeared very dusty. <i>Specify</i> _____				

Section 3: General Questions About Valley Fever		
<i>This section includes questions about Valley fever and working in dusty places. Answers to these questions can help improve public communications to prevent the disease.</i>		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	210. Before August 2018, had you heard of Valley fever (coccidioidomycosis)?
→ Skip if Q210 is No		211. If yes, where or how had you heard of it? Specify _____
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	212. Before August 2018, did you know that people can get fungal infections from breathing in dust in certain places?
<input type="checkbox"/>	<input type="checkbox"/>	213. Did you take any special efforts to reduce the amount of dust that was created?
→ Skip if Q213 is No		214. If yes, specify _____
215. What are ways that people can minimize the amount of dust they breathe when doing construction work? Specify _____		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	216. Did you take any special efforts to reduce the amount of dust that you inhaled?
→ Skip if Q216 is No		217. If yes, specify _____

Section 4: Questions About Your Experience After Returning from Mexico			
Yes	No	Don't Know	<i>Did you experience any of the following during or in the 4 weeks after your volunteer service trip to Mexico?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	218. Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	219. Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	220. Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	221. Chills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	222. Painful joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	223. Painful muscles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	224. Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	225. Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	226. Any rashes? (painful or itchy red lumps on skin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	227. Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	228. Headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	229. Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	230. Do you still have any of these symptoms?
231. Did you have any other symptoms? Specify _____			
232. Did you have any other symptoms? Specify _____			
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	233. Did you have any respiratory symptoms or fever (for example, like from a cold or flu) that started during your recent travel to Mexico or in the four weeks after returning?
→ Skip to Q245 if Q233 is No or Don't know			234. <i>If yes, what date did you first feel sick? (If you don't know, check the box for "don't know" and record your best guess)</i> ___ / ___ / _____ <input type="checkbox"/> Don't know M M D D Y Y Y Y
→ Skip to Q245 if Q233 is No or Don't know			235. <i>If yes, how many days did your illness last? Specify</i> _____
			Yes No
→ Skip if Q233 is No or Don't know			<input type="checkbox"/> <input type="checkbox"/> 236. Were you unable to do your normal activities because of this illness?
→ Skip if Q236 is No			237. <i>If yes, how many days? Specify</i> _____
			Yes No
→ Skip if Q233 is No or Don't know			<input type="checkbox"/> <input type="checkbox"/> 238. Did you visit the emergency room for this respiratory illness in July or August 2018?
→ Skip if Q233 is No or Don't know			<input type="checkbox"/> <input type="checkbox"/> 239. Were you hospitalized for this illness in July or August 2018?
→ Skip if Q239 is No			240. <i>If yes, how many days were you hospitalized in July or August 2018? Specify</i> _____

Public reporting burden of this collection of information is estimated to average 20 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)

	Yes	No	
→ Skip if Q239 is No	<input type="checkbox"/>	<input type="checkbox"/>	241. <i>If yes to hospitalized</i> , were you put on a ventilator (breathing machine) in July or August 2018?
→ Skip if Q241 is No	242. <i>If yes</i> , how many days were you on a ventilator in July or August 2018? Specify _____		
	Yes	No	
→ Skip if Q239 is No	<input type="checkbox"/>	<input type="checkbox"/>	243. <i>If yes to hospitalized</i> , were you in the intensive care unit in July or August 2018?
→ Skip if Q243 is No	244. <i>If yes</i> , how many days were you in the intensive care unit in July or August 2018? Specify _____		
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	245. Did you see a healthcare provider during your recent travel to Mexico or in the four weeks after returning to the United States?
→ Skip if Q245 is No	246. <i>If yes to healthcare provider</i> , what was the reason for visiting a healthcare provider? Specify _____		
→ Skip if Q245 is No	247. <i>If yes to healthcare provider</i> , how many times did you visit a healthcare provider during this period? <input type="checkbox"/> once <input type="checkbox"/> twice <input type="checkbox"/> three times <input type="checkbox"/> four times <input type="checkbox"/> five times or more		
	Yes	No	
→ Skip if Q245 is No	<input type="checkbox"/>	<input type="checkbox"/>	248. <i>If yes to healthcare provider</i> , was this for any type of respiratory symptoms or fever (for example, like from a cold or flu)?
→ Skip if Q248 is No	249. <i>If yes to respiratory symptoms</i> , what did the healthcare provider tell you was the cause of your illness? Specify _____ <input type="checkbox"/> Don't know		
	Yes	No	Don't Know
→ Skip if Q245 is No or Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			250. Did you receive a chest x-ray in July or August 2018?
→ Skip if Q245 is No or Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			251. Were you given any medication for this respiratory illness in July or August 2018?
→ Skip if Q245 is No or Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			252. Did you take anti-fungal medication (Examples: Amphotericin B, Ambisome, Diflucan, Fluconazole, Itraconazole, Voriconazole, Posaconazole)?
→ Skip if Q245 is No or Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			253. Did you take antibiotic medication (Example: amoxicillin, doxycycline, cephalixin, ciprofloxacin, clindamycin, metronidazole, azithromycin, sulfamethoxazole/trimethoprim)?
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	254. Did you take anything over the counter (without prescription)?
→ Skip if Q254 is No or Don't know	255. <i>If yes to over the counter</i> , specify medication _____		
Yes	No	Don't Know	

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	256. Were you ever diagnosed with Valley fever before traveling to Mexico in summer 2018?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	257. Were you diagnosed with Valley fever after returning from Mexico in summer 2018?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	258. Did you take a corticosteroid (for example, prednisone) in the 4 weeks before your recent travel to Mexico?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	259. Do you have diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	260. Do you have lung disease such as COPD, asthma, or emphysema?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	261. Do you have any condition that weakens your immune system (for example, cancer, HIV, transplant, or medication that weakens your immune system)?
→ Skip if Q261 is No or Don't know			262. If yes, specify _____

Section 5: Demographic Questions	
263. Which State and city do you reside in?	State _____ City _____
264. Age _____	265. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
266. How do you describe your race? (select all that apply)	
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
267. How do you describe your ethnicity?	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
268. What is your occupation? <input type="checkbox"/> Student <input type="checkbox"/> Faculty <input type="checkbox"/> Other. Specify _____	
269. What is the name of the school you attend or teach at? Specify _____	

Section 6: COMMENTS
<i>If there is any other information you would like to share about your travel or Valley fever?</i>