Acute Flaccid Myelitis Case Questionnaire

|  |  |
| --- | --- |
| **Section 1: Interviewer & Patient Information** *(Questions 1-10 to be completed by interviewer prior to questionnaire administration)* | |
| 1. CDC ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. State/Local/Other ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Date of Interview: | \_\_ \_\_ /\_ \_ / \_\_ \_\_ \_\_ \_\_ *(if Don’t know, enter 99/99/9999)*  M M/D D/Y Y Y Y |
| 1. Interviewer Information Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency or Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Interview conducted  By Phone  In Person | |
| 1. State and county of residence? State \_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Sex:  Male  Female  Don’t know | |
| 1. Date of Birth : \_\_ \_\_ /\_ \_ / \_\_ \_\_ \_\_ \_\_ *(if Don’t know, enter 99/9999) or Age at limb weakness onset date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*   M M/D D/Y Y Y Y | |
| 1. Limb weakness onset date: \_\_ \_\_ /\_ \_ /\_\_ \_\_ \_\_ \_\_ *(if Don’t know, enter 99/9999)* | |

*(Please remember to use the appropriate language if the interviewee is the patient (adult case) or the parent of a child. Please do not interview children under 18 years old. Text in italics is for your information only and not to be read to the interviewee.)*

**Hello, my name is\_\_\_\_\_\_\_\_\_, and I am a [insert title] that works for [insert health department name]. May I please speak to a parent or guardian of [name]?**

**(If parent not there) OK. Can you suggest a better time to call back to reach \_\_\_\_\_\_\_\_\_\_?**

**(If yes, parent/guardian) CDC has confirmed [name]‘s case of AFM. We’d like to learn more about your child’s illness with AFM. We hope to take about an hour of your time. Is this a good time to talk?**

**(If no) Is there a better time that I may call back? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you. To start I just want to tell you a little bit about why we want to ask you these questions. We have learned a lot about AFM in the past few years and we think viruses likely play a role in AFM. We would like to go through the course of [name]’s illness with you to learn more about how [his/her/your] symptoms developed. And for completeness, we will also ask you some questions about other things like contact with animals, activities, travel, and household items that are often asked about when we are trying to learn more about an illness. Your answers may help us understand more about this illness, and in turn help [name] and others.**

**We want you to know that just because we ask a question about an activity or product does not mean that we believe it is harmful or causes AFM; these questions will help us focus future work to understand AFM. If there are any questions you don’t feel comfortable answering, please let me know and we will skip them and move on.**

1. Respondent was:  Patient (>18 years old)  Mother  Father  Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Language interview conducted in  English  Spanish  Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

**First, I’d like to confirm a few details about [name] with you.**

1. **Date of Birth: \_\_ \_\_/\_ \_ /\_\_ \_\_ \_\_ \_\_ *(if Don’t know, enter 99/9999)***

M M/D D/Y Y Y Y

1. **Is [name] (are you) Hispanic or Latino?**

Hispanic or Latino  Not Hispanic or Latino

1. **How would you describe [name]’s race? You can say yes to all that apply:**

American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White

1. **Did [name] experience limb weakness during 2018?**

No  Yes

(If yes) our records show that the weakness started on \_\_\_/\_\_\_/\_\_\_\_

Is this right?  No  Yes  Don’t know (if no) record date on \_\_\_/\_\_\_/\_\_\_\_

1. **Did [name] receive a diagnosis of AFM from a doctor?**

Yes  No  Don’t know

**If no, what was your (child’s) diagnosis(es)**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Interviewee information

1. *(If interviewing patient, skip to 18b)* **a. Does [name] live with you?**

No, Do not live together. *(If interviewee is not the primary parent, please ask to speak to the primary parent or for their contact information*)

Yes, Live together, Full time *(Please fill out b-c)*  Yes, Part time: describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(Please fill out b-d)*

**b.** How many people lived with you at the time [name] got sick? \_\_\_\_\_\_\_\_\_\_\_

**c.** Can you tell me their names and ages and relationship to [name], including yourself? If you don’t want to give names, we can do what you are comfortable with like use initials. *(Please add this information to Household 1 table).*

**d.** *(For those who live part time)* Can you tell me about {name]’s other household? How many people were living there when he/she/you got sick? \_\_\_\_\_\_\_\_\_\_ *(Please mark this in Household 2)*

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOUSEHOLD 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Initials** | **Age (at the time of AFM patient’s illness)** | **Relationship** | **Is relationship step, half, or full?** |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |

**HOUSEHOLD 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Initials** | **Age (at the time of AFM patient’s illness)** | **Relationship** | **Is relationship step, half, or full?** |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |
|  |  | Mother  Father  Sister  Brother  Grandmother  Grandfather  Other\_\_\_\_\_\_\_\_\_\_ | Step  Half  Full |

# Medical history

**Now I’d like you to think back to [name]’s (your) health before s/he developed AFM.**

1. **Was [name] born full-term or preterm (less than 36 weeks)?**

Full-term (37-40+ weeks)

Preterm (<36 weeks)

Don’t know

1. **Before [name] got sick, what kinds of doctors did he/she see regularly?**

Pediatrician  Neurologist, for \_\_\_\_\_\_\_\_\_\_\_  Immunologist, for \_\_\_\_\_\_\_\_\_\_\_\_  Dermatologist for \_\_\_\_\_\_\_\_\_\_\_  Allergist, for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENT, for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other, describe & for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Has [name] (Have you) ever been diagnosed with any of the following conditions or have any medical conditions for which s/he regularly visits the doctor or takes regular medication for prior to onset of AFM?** *(Please indicate for which condition medication is taken)*

| **Condition** | **Did he/she take medication for this?** | **What kind of medication?** | **How often?** | **Comments** |
| --- | --- | --- | --- | --- |
| **Atopy** |  |  |  |  |
| **Asthma** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  OTC Allergy medication  Inhaler  Other \_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Eczema** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  OTC Allergy medication  Inhaler  Other \_\_\_\_\_\_\_ | On a regular basis  As needed |  |

| **Condition** | **Did he/she take medication for this?** | **What kind of medication?** | **How often?** | **Comments** |
| --- | --- | --- | --- | --- |
| **Allergies**  **If yes, what is the allergy to?**  **Seasonal allergy**  **Food**  **Medication**  **Bees**  **Other please describe\_\_\_\_\_\_\_\_** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  Inhaler  Topical  Oral/pill  OTC Allergy medication  Inhaler  Other\_\_\_\_\_\_\_\_\_\_\_\_  Does he/she get allergy shots?  Yes (currently)  Yes (past, no longer receiving)  No  Don’t know | On a regular basis  As needed |  |
| **Immunodeficiency /weakened immune system (severe combined immunodeficiency (SCID), conditions requiring a stem cell transplant, antibody deficiency)**  **If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Lyme disease** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  OTC Allergy medication  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Malnourishment or vitamin/mineral deficiency** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Eating disorder** | Yes  No | Med name\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |

| **Condition** | **Did he/she take medication for this?** | **What kind of medication?** | **How often?** | **Comments** |
| --- | --- | --- | --- | --- |
| **Autoimmune conditions** | | | | |
| **Rheumatoid arthritis** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  Non-steroidal anti-inflammatory  ( OTC RX)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Inflammatory bowel disease (IBD) (eg Crohn’s and ulcerative colitis) Note: NOT IBS** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  Non-steroidal anti-inflammatory  ( OTC RX)  Other immunosuppressant, \_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Type 1 diabetes** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Psoriasis** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  Non-steroidal anti-inflammatory  ( OTC RX)  Other immunosuppressant, \_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Inhaled  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Condition** | **Did he/she take medication for this?** | **What kind of medication?** | **How often?** | **Comments** |
| **Lupus** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  Non-steroidal anti-inflammatory  ( OTC RX)  Other immunosuppressant, \_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Thyroid disease (Hashimoto’s, Graves’)** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Other autoimmune condition**  **Describe\_\_\_\_\_\_\_\_\_\_\_\_\_** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid/prednisone  Non-steroidal anti-inflammatory  ( OTC RX)  Other immunosuppressant, \_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Inhaled  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Congenital condition (e.g., conditions your child had at birth such as cleft palate and cleft lip, heart defects, spina bifida), describe,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Inhaled  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **Other condition describe,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Inhaled  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |

| **Condition** | **Did he/she take medication for this?** | **What kind of medication?** | **How often?** | **Comments** |
| --- | --- | --- | --- | --- |
| **Are there any other medications that s/he is taking routinely?** | Yes  No | (Medication Name)\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this medication given  Orally  Inhaled  Topical  Injection  Other\_\_\_\_\_\_\_\_ | On a regular basis  As needed |  |
| **No medical conditions reported**  **Don’t know** |  |  |  |  |

1. **Before [name] developed AFM— was [name] ever admitted to the hospital (stayed overnight) for any reason?**

Yes  No  Don’t know

**If yes, How many times has [name] (have you) been hospitalized overnight?** #\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospitalization #** | **What was the date of hospitalization? (MM/YYYY)** | **What was the reason for hospitalization?** | **Briefly describe (presenting reason, cause (if applicable)** |
| **1** |  | Illness  Surgery  Trauma  Other, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **2** |  | Illness  Surgery  Trauma  Other, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **3** |  | Illness  Surgery  Trauma  Other, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. **Next we’d like to know if [name] has any blood relatives that have been diagnosed with any of the following conditions:**

*(Please add comments as necessary; such as the interviewee’s level of certainty about a diagnosis or disease severity.)*

| **Condition** | **Immediate Family** | | **Maternal relatives** | | **Paternal relatives** | | **Comments** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Asthma** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Eczema** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Allergies**  **Seasonal allergy**  **Food**  **Medication**  **Bees**  **Other\_\_\_\_\_\_\_\_** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Immunodeficiency/weakened immune system (eg antibody deficiency, condition requiring a stem cell transplant)** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Lyme disease** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Autoimmune conditions** | | | | | | | |
| **Rheumatoid arthritis** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Inflammatory bowel disease (IBD) (eg Crohn’s and ulcerative colitis)** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Type 1 diabetes** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Psoriasis** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Lupus** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Thyroid disease (Hashimoto’s, Graves’)** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Other autoimmune condition**  **Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Neurologic illness** | | | | | | | |
| **Polio** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Transverse myelitis** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Guillain-Barre Syndrome** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Parkinson’s disease** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Epilepsy** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Dementias (eg Alzheimer’s)** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Multiple sclerosis** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **Other neurologic illness, describe\_\_\_\_\_\_\_\_\_\_** | Mother  Father | Sister  Brother | Grandmother  Grandfather | Aunt  Uncle | Grandmother  Grandfather | Aunt  Uncle |  |
| **No medical conditions** | | | | | | | |
| **Do not know** | | | | | | | |

# Illness history (30 days)

**Now I’d like to ask some questions about the time when [name] developed limb weakness. For many questions we are interested in the 30 days prior to limb weakness. It may be helpful to look at a calendar for these questions.**

1. **As we discussed earlier, *[name]* first experienced limb weakness on \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ (MM/DD/YYYY)**

**Based on this information the 30 day period before [name]’s (your) limb weakness would be the period from \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_.**

1. **In the 30 days before limb weakness onset, did *[name]* have any medical or dental procedures (including dental work like a cavity filling, tonsillectomy, or ear tubes)?**

Yes  No  Don’t know

**If yes, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ approximate date \_\_/\_\_\_/\_\_\_\_\_

1. **In the 30 days before limb weakness onset, did *[name]* experience any physical trauma?** **This may include experiences such as a broken bone, injury requiring stitches, animal bite, or concussion.**

Yes  No  Don’t know

**If yes,**

**What was the approximate date? \_\_/\_\_\_/\_\_\_\_\_**

**What type of trauma?**   Broken bone  injury requiring stitches  Concussion  Animal bite  Other, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where on the body was the trauma? *Check all that apply.***

Head  Neck  Leg ( Left  Right)  Arm ( Left  Right)  Trunk  Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **In the 30 days before limb weakness onset, did *[name]* receive any shots? This may include vaccinations, flu shots, steroid injection, allergy shots, antibiotics injection, vitamin injections, other medications, etc.**   Yes  No  Don’t know

**If yes, please answer the following questions about each injection.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of injection?** | **Description of injection (name, reason)** | **Date (DD/MM/YYYY)** | **Reaction?** | **Location of injection** |
| Routine childhood vaccination  Flu shot  Antibiotic  Steroid  Other medication  Allergy shot  Vitamin/supplement  Other |  | \_\_/\_\_/\_\_\_\_ | Soreness around injection site  Fever  Other | Upper arm  Right  Left  Thigh  Right  Left  Buttocks  Other, describe\_\_\_\_\_\_\_\_ |
| Routine childhood vaccination  Flu shot  Antibiotic  Steroid  Other medication  Allergy shot  Vitamin/supplement  Other |  | \_\_/\_\_/\_\_\_\_ | Soreness around injection site  Fever  Other | Upper arm  Right  Left  Thigh  Right  Left  Buttocks  Other, describe\_\_\_\_\_\_\_\_ |
| Routine childhood vaccination  Flu shot  Antibiotic  Steroid  Other medication  Allergy shot  Vitamin/supplement  Other |  | \_\_/\_\_/\_\_\_\_ | Soreness around injection site  Fever  Other | Upper arm  Right  Left  Thigh  Right  Left  Buttocks  Other, describe\_\_\_\_\_\_\_\_ |
| Routine childhood vaccination  Flu shot  Antibiotic  Steroid  Other medication  Allergy shot  Vitamin/supplement  Other |  | \_\_/\_\_/\_\_\_\_ | Soreness around injection site  Fever  Other | Upper arm  Right  Left  Thigh  Right  Left  Buttocks  Other, describe\_\_\_\_\_\_\_\_ |

1. **In the 30 days before limb weakness onset, did [name] come down with symptoms of an illness? These may include cold, cough, stomach aches, vomiting or diarrhea, body aches, fever, or other symptoms.** *(Some symptoms like fever may go away and then reappear right before limb weakness. Please record symptoms that recur as a separate illness in the second illness section.)*

Yes  No  Don’t know (if no or Don’t know, skip to question 30)

**Illness #1: Did s/he have any of the following symptoms?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptoms (check yes or no for each)** | **Approximate date (DD/MM/YYYY)** | **Days prior to limb weakness** | **Were these symptoms present when limb weakness developed?** |
| Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure) |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Cold symptoms?  Yes  No  Cough  Runny nose  Congestion  Sore throat |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Other Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_days  Don’t know | Yes  No |

1. **In the 30 days before limb weakness onset, did s/he have any other episodes of illness?**

Yes  No  Don’t know (if no or Don’t know, skip to question 30)

**Illness #2:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptoms (check yes or no for each)** | **Approximate date (DD/MM/YYYY)** | **Days prior to limb weakness** | **Were these symptoms present when limb weakness developed?** |
| Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure) |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Cold symptoms?  Yes  No  Cough  Runny nose  Congestion  Sore throat |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth |  | \_\_\_\_\_days  Don’t know | Yes  No |
| Other Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_days  Don’t know | Yes  No |

1. **Were any household members sick in the 30 days before you or [name]’s limb weakness?**

Yes  No  Don’t know (if no or Don’t know, skip to question 31)

*(If the interviewee doesn’t recall all of the details, please mark don’t know and add any additional comments at the end of the table.)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Household member (Relationship and age)** | **Symptoms (check yes or no for each)** | **Duration of illness (days)** | **Did they seek medical attention?** | **Did [this person] get sick before or after [name]?** |
| Household member #1 (Relationship and age) | Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure)  Cold symptoms?  Yes  No  Cough  Runny nose  Congestion?  Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains  Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth  Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_days  Don’t know | Yes, \_\_\_\_\_\_\_\_\_  No  Don’t know | AFM patient did not have any illness before limb weakness  Before  After  Same time  Don’t know |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Household member (Relationship and age)** | **Symptoms (check yes or no for each)** | **Duration of illness (days)** | **Did they seek medical attention?** | | **Did [this person] get sick before or after [name]?** |
| Household member #2 (Relationship and age) | Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure)  Cold symptoms?  Yes  No  Cough  Runny nose  Congestion?  Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains  Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth  Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_days  Don’t know | Yes, \_\_\_\_\_\_\_\_\_  No  Don’t know | | AFM patient did not have any illness before limb weakness  Before  After  Same time  Don’t know |
| Household member #3 (Relationship and age) | Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure)  Cold symptoms?  Yes  No  Cough  Runny nose  Congestion?  Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains  Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth  Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_days  Don’t know | Yes, \_\_\_\_\_\_\_\_\_  No  Don’t know | | AFM patient did not have any illness before limb weakness  Before  After  Same time  Don’t know |
| **Household member (Relationship and age)** | **Symptoms (check yes or no for each)** | **Duration of illness (days)** | **Did they seek medical attention?** | | **Did [this person] get sick before or after [name]?** |
| Household member #4 (Relationship and age) | Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure)  Cold symptoms?  Yes  No  Cough  Runny nose  Congestion?  Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains  Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth  Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_days  Don’t know | Yes, \_\_\_\_\_\_\_\_\_  No  Don’t know | AFM patient did not have any illness before limb weakness  Before  After  Same time  Don’t know | |
| Household member #5 (Relationship and age) | Fever?  Yes  No  If yes, what was the highest measured? \_\_\_\_\_\_\_  Subjective (d/n measure)  Cold symptoms?  Yes  No  Cough  Runny nose  Congestion?  Gastrointestinal symptoms?  Yes  No  Vomiting  Diarrhea  Nausea  Stomach pains  Rashes/Sores?  Yes  No  Rash/sores on the palms  Rash/sores on the soles of the feet  Rash/sores in the diaper/underwear region  Sores in the mouth  Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_days  Don’t know | Yes, \_\_\_\_\_\_\_\_\_  No  Don’t know | AFM patient did not have any illness before limb weakness  Before  After  Same time  Don’t know | |
| *(Please capture In what order did these family members (including [name]) got sick.)* | | | | | |
| Additional comments: | | | | | |

# Care received

**Now we’d like to hear about visits to the doctor from the 30 days before limb weakness onset to when [name] was admitted to the hospital.**

1. **How many times did [name] see a doctor before hospitalization? #\_\_\_\_\_\_\_\_\_\_\_\_**
2. **I’d like to ask you a few questions about each visit. Let’s start with the first time [name] saw a doctor.**

*(If limb weakness was the reason for the visit, please either put the date or ‘0’ days before limb weakness. All patients should have at least one entry for this table. If the patient was admitted to the hospital as a result of the first visit to a doctor or clinic, please record the details that led up to the hospitalization. We do not need information from after admittance)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Visit 1** | **Visit 2** | **Visit 3** | **Visit 4** |
| **Where was *[name]* seen?** | Doctor’s office  Urgent care  Emergency room  Other, describe  \_\_\_\_\_\_\_\_\_\_\_\_ | Doctor’s office  Urgent care  Emergency room  Other, describe  \_\_\_\_\_\_\_\_\_\_\_\_ | Doctor’s office  Urgent care  Emergency room  Other, describe  \_\_\_\_\_\_\_\_\_\_\_\_ | Doctor’s office  Urgent care  Emergency room  Other, describe  \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Why did you take [name] to the doctor?** |  |  |  |  |
| **Number of days before or after limb weakness onset of limb weakness** |  |  |  |  |
| **Who saw [name]?** | Nurse  Doctor (Ped/FP)  Specialist, specify\_\_\_\_\_\_\_\_  Other, specify\_\_\_\_\_\_\_\_\_\_\_  Don’t know | Nurse  Doctor (Ped/FP)  Specialist, specify\_\_\_\_\_\_\_\_  Other, specify\_\_\_\_\_\_\_\_\_\_\_  Don’t know | Nurse  Doctor (Ped/FP)  Specialist, specify\_\_\_\_\_\_\_\_  Other, specify\_\_\_\_\_\_\_\_\_\_\_  Don’t know | Nurse  Doctor (Ped/FP)  Specialist, specify\_\_\_\_\_\_\_\_  Other, specify\_\_\_\_\_\_\_\_\_\_\_  Don’t know |
| **Did [name] receive a diagnosis?** | Yes, specify\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Yes, specify\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Yes, specify\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | Yes, specify\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Visit 1** | **Visit 2** | **Visit 3** | **Visit 4** |
| **Did the doctor recommend any medications or treatments?** | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know |
| **What medications were given/prescribed?** | Steroids  Antibiotics  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | Steroids  Antibiotics  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | Steroids  Antibiotics  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | Steroids  Antibiotics  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Did the medications result in any improvement?** | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know | Yes  No  Don’t know |
| **Did the doctor decide to admit [name] to the hospital on this visit?** | Yes  No | Yes  No | Yes  No | Yes  No |
| **Comments:** |  |  |  |  |

1. **In the 30 days before limb weakness onset, did [name] take any prescription or over-the-counter medications or supplements? This could include antibiotics, medications for asthma or allergies, vitamins, herbal or homeopathic remedies, nutritional supplements, or topical treatments like vapor rubs.** *(If any medications were noted above, please repeat them here to confirm was taken in the 30 days prior to limb weakness.)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication (name)** | **Type of medication** | **Method of administration** | **Frequency** |
|  | Steroid/prednisone  Antibiotic  Insulin  ADHD med  OTC pain med/fever reducer  OTC cold/cough  Herbal or homeopathic remedies  Vitamins or nutritional supplements  Topical treatments  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t know | Inhaler  Oral  Topical  Injection  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed  One time prescription |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication (name)** | **Type of medication** | **Method of administration** | **Frequency** |
|  | Steroid/prednisone  Antibiotic  Insulin  ADHD med  OTC pain med/fever reducer  OTC cold/cough  Herbal or homeopathic remedies  Vitamins or nutritional supplements  Topical treatments  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t know | Inhaler  Oral  Topical  Injection  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed  One time prescription |
|  | Steroid/prednisone  Antibiotic  Insulin  ADHD med  OTC pain med/fever reducer  OTC cold/cough  Herbal or homeopathic remedies  Vitamins or nutritional supplements  Topical treatments  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t know | Inhaler  Oral  Topical  Injection  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | On a regular basis  As needed  One time prescription |

1. **In the 30 days prior to limb weakness, did [name] follow any of the following special or restricted diets? (if yes/maybe please check all that apply)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | | Kosher | Halal | Raw foods | | Low carb | Paleo (high protein, low carb) | Vegetarian/Vegan | | Dairy-free | Gluten-free | Weight loss/low fat | | Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

1. **In the 30 days before limb weakness, did [name] consumed any raw or unpasteurized dairy products from a cow or other animal source? These might include raw milk, or homemade, farm‐fresh, and door‐to‐door cheeses.**

**If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Contacts

**In this section we’d like to learn more about who *[name]* interacted with in the 30 days prior to developing their limb weakness.**

1. **In the 30 days before limb weakness onset, did [name] attend daycare or school?**

Yes  No, did not attend daycare or school  Don’t know

**If yes, specify:**

Daycare/Preschool (exclude nanny)  School (K-12)  Home schooled

1. **In the 30 days before limb weakness onset, did [name] attend any of the following activities with other kids?**

Before- or After-school Care  Dance/sports/music/art class  Scouts  Day camp

Sleepaway camp  Church/Religious school  Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No, did not attend any activities

1. **In the 30 days before limb weakness onset, did *[name]*’s daycare or school report any of the following illnesses amongst students?**

Respiratory infections  Hand-foot-mouth disease  Meningitis  Acute flaccid myelitis  Don’t know  No

1. **In the 30 days before illness onset, did [name] participate in any of the following recreational water activities (select all that apply):**

Water park

Lake/River

Beach

Public pool

Private residence pool

Don’t know

Splash pad

Other\_\_\_\_\_\_\_\_\_\_

No

1. **In the 30 days before illness onset, did [name] participate in any of the following outdoor activities (select all that apply):**

Camping

Amusement park

Gardening/raking/moving/digging in soil

Playing in sandbox

Going to a farm/petting zoo

Fishing

Hiking

Eating or picking wild plants (fruit, seeds, etc.) or mushrooms

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Don’t know

No

# Travel history

1. **In the 30 days before limb weakness onset, did [name] take any overnight, out-of-town trips in the US or internationally?** *(Photos and social media can help with remembering dates and places)*

Yes  No  Don’t know

**If yes, please describe**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **City, State or**  **City, Country** | **When did s/he go? (DD/MM/YYYY)** | **When did s/he come back? (DD/MM/YYYY)** | **How did s/he get there?** | **Did [name] come into contact with anyone sick?** |
|  | \_\_\_/\_\_\_/\_\_\_\_\_\_  Don’t know | \_\_\_/\_\_\_/\_\_\_\_\_\_  Don’t know | Personal vehicle  Airplane  Train  Bus  Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes  No  Don’t know  If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_/\_\_\_/\_\_\_\_\_\_  Don’t know | \_\_\_/\_\_\_/\_\_\_\_\_\_  Don’t know | Personal vehicle  Airplane  Train  Bus  Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes  No  Don’t know  If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# Household

**Now I’d like to ask you some questions about the home where [name] lived in the 30 days before limb weakness onset.**

1. **Please describe the setting of this home:**

Urban  Suburban  Rural  Other, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please describe the type of housing:**

Apartment  Duplex  Townhouse  Single family home  Mobile home  Other, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **When was your home or apartment built?**

Before 1980?  After 1980  Don’t know

1. **Was there any remodeling or renovation work done inside or to the outside of your home during the 12 months before limb weakness? This might include new construction or remodeling portions of the home, painting or removing/scraping paint, removing or installing carpeting, etc.**

Yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know

1. **In the past 12 months has [name] ever lived next door to or very near any of the following (check all that apply)**

□ Industrial plant □ Commercial business □ Waste dump site □ Non-residential property □ Farm □ Construction site

1. **In the 12 months prior to [name]’s illness, did anyone in the household have a job that involves industrial chemicals or pesticides (eg** zinc smeltering, using or making pesticides, plastics, polymer, or other manufacturing) (check all that apply)

□ Industrial plant □ Commercial business □ Waste dump site □ Non-residential property □ Farm □ Construction site

1. **How often does anyone smoke (cigarettes, cigars, pipe tobacco, or marijuana) inside your home? Would you say daily, weekly, monthly, less than monthly, or never?**

□ daily □ Weekly □ Monthly □ Less than monthly □ Never □ Don’t know

# Specific Exposures: Vectors

1. **In the 30 days before limb weakness onset, was *[name]* ever in an environment where you or others saw mosquitoes?**

□ Yes □ No □ Don’t know

**If yes, was *[name]* bitten by a mosquito?** □ Yes □ No □ Don’t know

1. **In the 30 days before limb weakness onset, did you see a tick on [name]?**

□ Yes □ No □ Don’t know

**If yes, was *[name]* bitten by a tick?** □ Yes □ No □ Don’t know

# Specific Exposures: Environment

**\*\*\*If the child lives in multiple homes, please consider all homes in your answers to the questions in this section.\*\*\***

1. **In the 30 days before limb weakness onset, was [name] in direct contact with any of the following chemicals (eg helped apply the chemical, touched items with the chemical on it, chemical was applied in his/her room?)**

*Please select all that apply.*

□ Indoor pesticides or animal poison, describe type of contact with [name]\_\_\_\_

□ Outdoor pesticides or animal poison, describe type of contact with [name]\_\_\_\_

□ Outdoor fertilizer □ Solvents (paint thinner, lighter fluid, varnishes)

□ Insect repellents □ Treatments for scabies

□ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_

□ Indoor pesticides or animal poison, describe\_\_\_\_\_\_\_

□ Outdoor pesticides or animal poison, describe\_\_\_\_\_\_\_\_

□ Outdoor fertilizer

Solvens

□ Indoor pesticides or animal poison

□ Outdoor pesticides or animal poison

□ Outdoor fertilizer

□ Solvents (paint thinner, lighter fluid, varnishes)

□ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_

□ Solvents (paint thinner, lighter fluid, varnishes)

□ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_

□ Insect repellents

□ Treatments for scabies

1. **In the past 12 months has [name] ever lived next door to or very near any of the following (check all that apply)**

Industrial plant  Commercial business  Waste dump site  Non-residential property  Farm  Construction site

1. **In the 12 months prior to [name]’s illness, did anyone in the household have a job that involves industrial chemicals or pesticides (eg zinc smeltering, using or making pesticides, plastics, polymer, or other manufacturing) (check all that apply)**

Industrial plant  Commercial business  Waste dump site  Non-residential property  Farm  Construction site

1. **How often does anyone smoke (cigarettes, cigars, pipe tobacco, or marijuana) inside your home? Would you say daily, weekly, monthly, less than monthly, or never?**

Daily  Weekly  Monthly  Less than monthly  Never  Don’t know

# Specific Exposures: Vectors

1. **In the 30 days before limb weakness onset, was *[name]* ever in an environment where you or others saw mosquitoes?**

Yes  No  Don’t know

**If yes, was *[name]* bitten by a mosquito?**  Yes  No  Don’t know

1. **In the 30 days before limb weakness onset, did you see a tick on [name]?**

Yes  No  Don’t know

**If yes, was *[name]* bitten by a tick?**  Yes  No  Don’t know

# Specific Exposures: Environment

*(If the child lives in multiple homes, please consider all homes in your answers to the questions in this section.)*

1. **In the 30 days before limb weakness onset, was [name] in direct contact with any of the following chemicals (eg helped apply the chemical, touched items with the chemical on it, chemical was applied in his/her room?)**

*Please select all that apply.*

Indoor pesticides or animal poison, describe type of contact with [name]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outdoor pesticides or animal poison, describe type of contact with [name]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outdoor fertilizer □ Solvents (paint thinner, lighter fluid, varnishes)

Insect repellents □ Treatments for scabies

Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Indoor pesticides or animal poison, describe\_\_\_\_\_\_\_

□ Outdoor pesticides or animal poison, describe\_\_\_\_\_\_\_\_

□ Outdoor fertilizer

Solvens

□ Indoor pesticides or animal poison

□ Outdoor pesticides or animal poison

□ Outdoor fertilizer

□ Solvents (paint thinner, lighter fluid, varnishes)

□ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_

□ Solvents (paint thinner, lighter fluid, varnishes)

□ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_

□ insect repellents

□ treatments for scabies

1. **Were there any pets in [name]’s household in the 30 days before s/he got sick?**

Dog(s)  Cat(s)  Bird(s)  Small mammals (hamster, guinea pig, rabbits, etc)  Reptiles (snakes, lizards)  Bird(s)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **From where does [name] get drinking water? Please select all sources from which [name] has had water in the last 30 days before limb weakness onset.**  Municipal (Tap water)  Private well  Bottled  Stream/River/Lake  Other

**If other, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you treat your drinking water?**

Do not treat  Boil  Add bleach/chlorine  Use a water filter  Deionize  Other

**If yes OR other, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# A few last things

1. **Thanks for finishing the questionnaire….How is [name] doing?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **If you wish to share, what do you think caused you or [name]’s illness?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Is there anything else you would like to share, or anything additional about you or [name] that you think we should know?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**That completes the interview. Thank you for taking the time to answer these questions. Your responses may be helpful in preventing others from becoming sick. If you have more questions about AFM please consult our website at:** [**https://www.cdc.gov/acute-flaccid-myelitis**](https://www.cdc.gov/acute-flaccid-myelitis)