Form Approved
OMB No. 0920-1011
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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 #: _____	
2.	State/Local/Other ID #: _____	
3.	Date of Interview:	__ __ /_ _ / __ __ __ __ *(if Don't know, enter 99/99/9999)* M M/D D/Y Y Y Y
4.	Interviewer Information Name: _____ Agency or Organization: _____	
5.	Interview conducted ☐ By Phone ☐ In Person	
6.	State and county of residence? State _____ County _____	
7.	Patient name_____	
8.	Sex: ☐ Male ☐ Female ☐ Don't know	
9.	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	
10.	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.

11. Respondent was: ☐ Patient (>18 years old) ☐ Mother ☐ Father ☐ Other (specify):_____
12. Language interview conducted in ☐ English ☐ Spanish ☐ Other (specify):_____

PATIENT INFORMATION

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

13. Date of Birth: __ __/_ _ /__ __ __ __ *(if Don't know, enter 99/9999)*
M M/D D/Y Y Y Y
14. Is [name] (are you) Hispanic or Latino?
☐ Hispanic or Latino ☐ Not Hispanic or Latino
15. 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
16. 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 ___/___/____
17. 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

18. *(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.

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

☐ Full-term (37-40+ weeks)

☐ Preterm (<36 weeks)

☐ Don't know

20. 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 _____

21. 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**	**What kind of medication?**	**How often?**	**Comments**

	this?			
☐ **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**				

22. 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_____	

23. 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 ☐ Sister ☐ Father ☐ Brother	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	
☐ **Eczema**	☐ Mother ☐ Sister ☐ Father ☐ Brother	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	
☐ **Allergies** ☐ **Seasonal allergy** ☐ **Food** ☐ **Medication** ☐ **Bees** ☐ **Other_____**	☐ Mother ☐ Sister ☐ Father ☐ Brother	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	
☐ **Immunodeficiency/weakened immune system (eg antibody**	☐ Mother ☐ Sister ☐ Father ☐ Brother	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	☐ Grandmother ☐ Aunt ☐ Grandfather ☐ Uncle	

Condition	Immediate Family		Maternal relatives		Paternal relatives		Comments
deficiency, condition requiring a stem cell transplant)							
☐ **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.

24. **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 ____/____/_____.

25. **<u>In the 30 days before limb weakness onset</u>, 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 __/___/_____

26. **<u>In the 30 days before limb weakness onset</u>, 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: _____

27. **<u>In the 30 days before limb weakness onset</u>, 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________

28. <u>In the 30 days before limb weakness onset</u>, 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

29. <u>In the 30 days before limb weakness onset</u>, 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

30. <u>Were any household members sick in the 30 days before you or [name]'s limb weakness?</u>

☐ 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	Fever? ☐ Yes ☐ No	_____days	☐ Yes,	☐ AFM patient did not have any illness

(Relationship and age)	☐ 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 _____	☐ Don't know	_____ ☐ No ☐ Don't know	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.

31. How many times did [name] see a doctor before hospitalization? #_____

32. 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:				

33. **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

34. 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: _____		

35. **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.

36. **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

37. **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

38. **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

39. **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

40. **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

41. 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.

42. Please describe the setting of this home:

☐ Urban ☐ Suburban ☐ Rural ☐ Other, describe_____

43. Please describe the type of housing:

☐ Apartment ☐ Duplex ☐ Townhouse ☐ Single family home ☐ Mobile home ☐ Other, describe_____

44. When was your home or apartment built?

☐ Before 1980? ☐ After 1980 ☐ Don't know

45. 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

47. 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

48. 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)

□ 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

46. 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

47. 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

48. 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

49. 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

50. 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.)

51. 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

52. 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 _____

53. 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: _____

54. 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

55. Thanks for finishing the questionnaire….How is [name] doing?

_____

_____

56. If you wish to share, what do you think caused you or [name]'s illness?

_____

_____

57. 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