

CANINE EXPOSURE QUESTIONNAIRE

Notes to Interviewer:

Questionnaire to be used for individuals who have had exposure to a dog/puppies or a pet store/environment.

- *Instructions in italics are for interviewer only. Do not read italicized words to person being interviewed.*
- *Administer questionnaire to the patient (or patient's caregiver).*
- *Complete one form for every patient and complete as much information as possible. Thank you!*

Epi Info ID

Section 1: Interview information (Complete before administering questionnaire)

1. PulseNet ID #: _____	2. State/Local/Other ID #: _____
3. PulseNet cluster code: _____	3a. PFGE Pattern: _____
	3b. Campylobacter Strain _____
4. Date of Interview: <u> </u> / <u> </u> / <u> </u> - <u> </u> - <u> </u> (If unknown, enter 99/99/9999) <small style="text-align: center;">M M D D Y Y Y Y</small>	
Interviewer information	5. Name: _____
	6. Agency: _____
7. Contact phone number: (____) _____ - _____	
8. Did the patient die? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
8a: Date of death: <u> </u> / <u> </u> / <u> </u> - <u> </u> - <u> </u> (If unknown, enter 99/99/9999) <small style="text-align: center;">M M D D Y Y Y Y</small>	
8b: If the patient died, was it attributable to Campylobacter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
9. Respondent was: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Other, name and explain relation _____	

Read aloud before interview: My name is [name] and I'm with [organization]. We are investigating an outbreak of diarrhea caused by the *Campylobacter* germ. We believe you may have become sick with this germ, so I'd like to ask you a few questions. Your participation is completely voluntary, and you can discontinue the interview at any time. Any data we collect will be kept confidential, and your participation may help in the response and control of the outbreak. Do you agree to participate?

Section 2: DEMOGRAPHIC DATA

I'd like to begin by asking a few questions about the patient and the patient's household.

1. What are your state, county, and zip code? State abbr. _____ County _____ Zip Code _____	
2. Patient's age _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	3. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
4. How do you describe your/your child's race?	
<input type="checkbox"/> White	<input type="checkbox"/> Other race: _____
<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown
<input type="checkbox"/> Black/ African American	<input type="checkbox"/> Declined to answer
<input type="checkbox"/> Native American Indian/Alaska Native	
<input type="checkbox"/> Native Hawaiian/Pacific Islander (specify)	
5. How do you describe your/your child's ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer	
6. What is your/your child's occupation or job? _____	

Section 3: CLINICAL INFORMATION

Now I have a few questions about your/your child's illness.

1. What date did you/your child first feel sick? (I can wait while you get a calendar if you need to.)		<u> </u> / <u> </u> / <u> </u> - <u> </u> - <u> </u> <small style="text-align: center;">M M D D Y Y Y Y</small>	<input type="checkbox"/> Don't know
2. How many days total did your/your child's illness last? _____ days		<input type="checkbox"/> Don't know	<input type="checkbox"/> Still Ill
Yes	Maybe	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you/your child or Were you/your child:			
3. Have any diarrhea (3 or more loose stools in 24 hours)?			
		3a: What day did the diarrhea start? <u> </u> / <u> </u> / <u> </u> - <u> </u> - <u> </u> <small style="text-align: center;">M M D D Y Y Y Y</small>	
		3c. What was the highest number of loose stools you had in any 24 hours? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> >5	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have any bloody diarrhea? 4a: What day did the bloody diarrhea start? ___ / ___ / _____ <input type="checkbox"/> Don't know <small>M M D D Y Y Y Y</small> 4b: What day did the bloody diarrhea end? ___ / ___ / _____ <input type="checkbox"/> Still have blood <small>M M D D Y Y Y Y</small> <input type="checkbox"/> Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Have any fever (temperature measured at 100.4 F or higher)? 5a: What day did the fever start? ___ / ___ / _____ <input type="checkbox"/> Don't know <small>M M D D Y Y Y Y</small> 5b: What day did the fever end? ___ / ___ / _____ <input type="checkbox"/> Still have fever <small>M M D D Y Y Y Y</small> <input type="checkbox"/> Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Did you/your child seek medical care for this illness? 6a. Where did you seek medical care? Check all that apply. <input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Pharmacy clinic <input type="checkbox"/> Emergency department <input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Hospitalized for this illness? 7a. If hospitalized, how many nights? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Admitted to the intensive care unit (ICU) for this illness? 8a. If admitted to the ICU, how many nights? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Develop serious complications from this illness?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Prescribed an antibiotic (or multiple antibiotics) for this illness? Provide information about each course of antibiotics separately. 10a. Antibiotic #1 information Name: _____ <input type="checkbox"/> Don't know Start date: ___ / ___ / _____ Length of treatment (# of days): _____ <small>M M D D Y Y Y Y</small> 10b. Antibiotic #2 information Name: _____ <input type="checkbox"/> Don't know Start date: ___ / ___ / _____ Length of treatment (# of days): _____ <small>M M D D Y Y Y Y</small> 10c. Antibiotic #3 information Name: _____ <input type="checkbox"/> Don't know Start date: ___ / ___ / _____ Length of treatment (# of days): _____ <small>M M D D Y Y Y Y</small> 10d. Antibiotic #4 information Name: _____ <input type="checkbox"/> Don't know Start date: ___ / ___ / _____ Length of treatment (# of days): _____ <small>M M D D Y Y Y Y</small> 10e. Antibiotic #5 information Name: _____ <input type="checkbox"/> Don't know Start date: ___ / ___ / _____ Length of treatment (# of days): _____ <small>M M D D Y Y Y Y</small> 10f. Did your symptoms go away or get better after taking the antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know 10g. Did your symptoms stay the same or get worse despite taking antibiotics? <input type="checkbox"/> Stay same <input type="checkbox"/> Get worse <input type="checkbox"/> Don't know 10h. Did you/your child return to the doctor because of persistent symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know 10i. Did you/your child have a stool test return positive for <i>Campylobacter</i> after completing a course of antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Have any close contact with anyone with diarrhea or vomiting? 11a: When was the close contact ill? <input type="checkbox"/> during the 7 days before you got sick <input type="checkbox"/> more than 1 week before you got sick <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Have chronic diarrhea caused by a health condition or a medication <u>before</u> you got sick?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Immune-compromised at the time of illness due to a health condition or medication (e.g. cancer, HIV, diabetes, chemotherapy)? 13a. Name of condition or medication: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Did you take an antibiotic in the 30 days <u>before</u> you got sick? 14a. Antibiotic information Name: _____ <input type="checkbox"/> Don't know Start date: ___/___/____ Length of treatment (# of days): _____ <small>M M D D Y Y Y Y</small> Reason for antibiotic: _____

Section 4A: EXPOSURE DETAILS (AT HOME)

Now, I have a few questions about any interaction you/your child may have had with dogs/puppies at home in the 7 days before illness began, which is from ___/___/___ (subtract 7 days from onset date) to ___/___/___ (onset date).

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the 7 days before you/your child became ill, did you/your child have a dog/puppy in the household? (If "no" or "don't know" skip to Section 4B)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. What was the age of the dog/puppy at the time of your/your child's illness? <input type="checkbox"/> <6 months <input type="checkbox"/> 6 months - 1 year <input type="checkbox"/> >1 year <input type="checkbox"/> Don't know 3. What is the breed of your/your child's dog/puppy? <input type="checkbox"/> Unknown Breed 1: _____ Breed 2: _____ Breed 3: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Did you/your child touch the dog/puppy?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Did you/your child hold or snuggle the dog/puppy? (If "no" or "don't know" skip to Question 6) 5a. How often do you wash your hands/does your child wash his or her hands such as with soap and water or hand sanitizer after touching the dog/puppy? <input type="checkbox"/> Always or almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never 5b. What do you/does your child use to wash your/his or her hands after touching the dog/puppy? <input type="checkbox"/> Soap and water <input type="checkbox"/> Alcohol-based hand sanitizer <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/> Nothing/Do not wash hands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Did you/your child kiss the dog/puppy?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Did you/your child ever feed or give water to the dog/puppy?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Did you/your child ever touch the dog's/puppy's cage/enclosure? <input type="checkbox"/> Do not have cage/enclosure (If checked, skip to question 10)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Did you/your child clean the dog's/puppy's cage/enclosure? (If "no" or "don't know" skip to Question 10) 9a. How often do you wash your hands/does your child wash his or her hands such as with soap and water or hand sanitizer after touching the cage/enclosure? <input type="checkbox"/> Always or almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never 9b. What do you/does your child use to wash your/his or her hands after touching the cage/enclosure? <input type="checkbox"/> Soap and water <input type="checkbox"/> Alcohol-based hand sanitizer <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/> Nothing/Do not wash hands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Did you/your child pick up the dog's/puppy's poop? (If "no" or "don't know" skip to Question 11) 10a. How often do you wash your hands/does your child wash his or her hands such as with soap and water or hand sanitizer after picking up the poop? <input type="checkbox"/> Always or almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never 10b. What do you/does your child use to wash your/his or her hands after picking up the poop? <input type="checkbox"/> Soap and water <input type="checkbox"/> Alcohol-based hand sanitizer <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/> Nothing/Do not wash hands

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. In the 7 days before your/your child's illness began, did the dog/puppy have diarrhea? (If "no" or "don't know" skip to Question 12)
				11a. In the 7 days before your/your child's illness began, did your/your child's dog/puppy die?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. In the 30 days before your/your child's illness, was your/your child's dog/puppy purchased from a pet store? (If "no" or "don't know" skip to Section 4B)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. At what store did you purchase your dog? <input type="checkbox"/> Don't know Store Name: _____ Location: _____
				14. When did you purchase your dog? <input type="checkbox"/> Don't know M M / D D / Y Y Y Y
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you have a loyalty/shopper card for a pet store where a dog/puppy was purchased, and would you be willing to provide us the number? We will use this number to help gather information about dogs/puppies purchased. Store name: _____ Number: _____ Store name: _____ Number: _____
				16. Do you have the microchip number for your dog/puppy, and would you be willing to provide us the number? We may use this number to help determine where the dog came from, such as breeder. Microchip number: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Section 4B: DOG EXPOSURE DETAILS (OUTSIDE THE HOME)

Just a few more questions about any interaction you/your child may have had with dogs/puppies outside of your home in the 7 days before illness began, which is from ____ / ____ / ____ (subtract 7 days from onset date) to ____ / ____ / ____ (onset date).

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the 7 days before your/your child's illness began, did you/your child touch any dogs/puppies in a pet store, at a friend's house, or other location?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In the 7 days before you/your child's illness began, did you/your child touch any dog/puppy cages or other areas where dogs/puppies were present? (If "no" or "don't know" to Questions 1 and 2, skip to Section 5)
				3. Where did you/your child have contact with a dog/puppy or its cages/areas in the 7 days before you/your child became ill? (check all that apply) <input type="checkbox"/> Another person's home <input type="checkbox"/> Pet Store <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't know 3a. If at a pet store, please provide more information. Name of store: _____ Address of store: _____
				4. When did you/your child have contact with a dog/puppy outside your home? <input type="checkbox"/> Don't know M M / D D / Y Y Y Y M M / D D / Y Y Y Y
				5. What was the age of the youngest dog/puppy you/your child were in contact with? <input type="checkbox"/> <6 months <input type="checkbox"/> 6 months - 1 year <input type="checkbox"/> >1 year <input type="checkbox"/> Don't know
				6. What was (were) the breed(s) of dog/puppy you/your child had contact with? <input type="checkbox"/> Unknown Breed 1: _____ Breed 2: _____ Breed 3: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Did you/your child hold or snuggle the dog/puppy? (If "no" or "don't know" skip to Question 8)
				7a. How often do you wash your hands/does your child wash his or her hands such as with soap and water or hand sanitizer after touching the dog/puppy? <input type="checkbox"/> Always or almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
				7b. What do you/does your child use to wash your/his or her hands after touching the dog/puppy? <input type="checkbox"/> Soap and water <input type="checkbox"/> Alcohol-based hand sanitizer <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/> Nothing/Do not wash hands

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Did you/your child kiss the dog/puppy?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Did you/your child ever feed or give water to the dog/puppy?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Did you/your child ever touch the dog's/puppy's cage/enclosure?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Did you/your child clean the cage/enclosure? <i>(If "no" or "don't know" skip to Question 12)</i>
				11a. How often do you wash your hands/does your child wash his or her hands such as with soap and water or hand sanitizer after touching the cage/enclosure? <input type="checkbox"/> Always or almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
				11b. What do you/does your child use to wash your/his or her hands after touching the cage/enclosure? <input type="checkbox"/> Soap and water <input type="checkbox"/> Alcohol-based hand sanitizer <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/> Nothing/Do not wash hands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Did you/your child pick up the dog's/puppy's poop? <i>(If "no" or "don't know" skip to Question 13)</i>
				12a. How often do you wash your hands/does your child wash his or her hands such as with soap and water or hand sanitizer after picking up the poop? <input type="checkbox"/> Always or almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
				12b. What do you/does your child use to wash your/his or her hands after picking up the poop? <input type="checkbox"/> Soap and water <input type="checkbox"/> Alcohol-based hand sanitizer <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/> Nothing/Do not wash hands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. In the 7 days before your/your child's illness began, did any of the dogs/puppies you/your child had contact with have diarrhea? <i>(If "no" or "don't know" skip to Section 5)</i>
				13a. How many of the dogs/puppies had diarrhea? _____
				13b. Did any of the dogs/puppies die? <i>(If "no" or "don't know" skip to Section 5)</i>
				13c. <i>(If yes)</i> How many of the dogs/puppies died? _____

Section 5: OTHER ANIMAL EXPOSURE DETAILS

Now, I have a few questions about any interaction you/your child may have had with other animals in the 7 days before illness began.

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the 7 days before your/your child's illness began, did you/your child have any contact with any other animal? <i>(If "no" or "don't know" skip to Question 2)</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1a. Cat or kitten?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1b. Live poultry, such as chickens or ducks?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1c. Other birds, such as pet birds or wild birds, such as parrots or pigeons?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1d. Other animal: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1e. In the 7 days before your/your child's illness began, did you/your child have any contact with any animal that had diarrhea?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In the 7 days before your/your child's illness began, did you/your child work at any pet store?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. In the 7 days before your/your child's illness began, did you/your child visit any pet store?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the 7 days before your/your child's illness began, did you/your child work or visit a petting zoo, fair, exhibit or trade show?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. In the 7 days before your/your child's illness began, did you/your child work or visit a farm or ranch with animals present?

Section 6: AWARENESS AND EDUCATION

The final questions have to do with your awareness of the connection between dogs and *Campylobacter*.

Yes	Maybe	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Before this illness, were you aware of the connection between dogs/puppies and <i>Campylobacter</i> infection?
				1a: How did you find this information? (Check all that apply)
				<input type="checkbox"/> Magazine/newspaper
				<input type="checkbox"/> Website/blog
				<input type="checkbox"/> Employee at retail store
				<input type="checkbox"/> Sign at retail store
				<input type="checkbox"/> Friend/family
				<input type="checkbox"/> Television
				<input type="checkbox"/> Veterinarian
				<input type="checkbox"/> Healthcare Provider
				<input type="checkbox"/> Other: _____

Section 7: COMMENTS

Is there any other information you would like to share about this illness or about contact with dogs/puppies?

That was my last interview question. Thank you very much for your time and assistance.