

# Acute Flaccid Myelitis Case Questionnaire

<b>Section 1: INTERVIEWER &amp; PATIENT INFORMATION</b> (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 <input type="checkbox"/> By Phone <input type="checkbox"/> In Person	
6. State and county of residence? State _____ County _____	
7. Patient name _____	
8. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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?
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full

### HOUSEHOLD 2

Name/Initials	Age (at the time of AFM patient's illness)	Relationship	Is relationship step, half, or full?
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full

		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other_____	<input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Full
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## 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
<input type="checkbox"/> <b>Atopy</b>				
<input type="checkbox"/> <b>Asthma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name _____ <input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> OTC Allergy medication <input type="checkbox"/> Inhaler <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	
<input type="checkbox"/> <b>Eczema</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name _____ <input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> OTC Allergy medication <input type="checkbox"/> Inhaler <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	

Condition	Did he/she take medication for this?	What kind of medication?	How often?	Comments
<input type="checkbox"/> Allergies <b>If yes, what is the allergy to?</b> <input type="checkbox"/> Seasonal allergy <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Bees <input type="checkbox"/> Other please describe_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name_____ <input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> Inhaler <input type="checkbox"/> Topical <input type="checkbox"/> Oral/pill <input type="checkbox"/> OTC Allergy medication <input type="checkbox"/> Inhaler <input type="checkbox"/> Other_____ Does he/she get allergy shots? <input type="checkbox"/> Yes (currently) <input type="checkbox"/> Yes (past, no longer receiving) <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	
<input type="checkbox"/> Immunodeficiency /weakened immune system (severe combined immunodeficiency (SCID), conditions requiring a stem cell transplant, antibody deficiency) <b>If yes, describe_____</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name_____ <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	
<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name_____ <input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> OTC Allergy medication <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	
<input type="checkbox"/> Malnourishment or vitamin/mineral deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name_____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Med name_____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(Medication Name)_____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed	
<input type="checkbox"/> No medical conditions reported <input type="checkbox"/> Don't know		Is this medication given <input type="checkbox"/> Orally <input type="checkbox"/> Inhaled <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> Other_____		

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		<input type="checkbox"/> Illness <input type="checkbox"/> Surgery <input type="checkbox"/> Trauma <input type="checkbox"/> Other, describe_____	
2		<input type="checkbox"/> Illness <input type="checkbox"/> Surgery <input type="checkbox"/> Trauma <input type="checkbox"/> Other, describe_____	
3		<input type="checkbox"/> Illness <input type="checkbox"/> Surgery <input type="checkbox"/> Trauma <input type="checkbox"/> 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
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	
<input type="checkbox"/> Eczema	<input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	
<input type="checkbox"/> Allergies <input type="checkbox"/> Seasonal allergy <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Bees <input type="checkbox"/> Other_____	<input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	
<input type="checkbox"/> Immunodeficiency/weakened immune system (eg antibody)	<input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle	

Condition	Immediate Family		Maternal relatives		Paternal relatives		Comments
deficiency, condition requiring a stem cell transplant)							
<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> <b>Autoimmune conditions</b>							
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Inflammatory bowel disease (IBD) (eg Crohn's and ulcerative colitis)	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Type 1 diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Lupus	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Thyroid disease (Hashimoto's, Graves')	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Other autoimmune condition Describe _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> <b>Neurologic illness</b>							
<input type="checkbox"/> Polio	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Transverse myelitis	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Guillain-Barre Syndrome	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Dementias (eg Alzheimer's)	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> Other neurologic illness, describe _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Sister <input type="checkbox"/> Brother	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle	
<input type="checkbox"/> <b>No medical conditions</b>							
<input type="checkbox"/> <b>Do not know</b>							

## 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. **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 \_\_\_/\_\_\_/\_\_\_\_
26. **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: \_\_\_\_\_
27. **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
<input type="checkbox"/> Routine childhood vaccination <input type="checkbox"/> Flu shot <input type="checkbox"/> Antibiotic <input type="checkbox"/> Steroid <input type="checkbox"/> Other medication <input type="checkbox"/> Allergy shot <input type="checkbox"/> Vitamin/supplement <input type="checkbox"/> Other		__/__/____	<input type="checkbox"/> Soreness around injection site <input type="checkbox"/> Fever <input type="checkbox"/> Other	<input type="checkbox"/> Upper arm <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Thigh <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Buttocks <input type="checkbox"/> Other, describe_____
<input type="checkbox"/> Routine childhood vaccination <input type="checkbox"/> Flu shot <input type="checkbox"/> Antibiotic <input type="checkbox"/> Steroid <input type="checkbox"/> Other medication <input type="checkbox"/> Allergy shot <input type="checkbox"/> Vitamin/supplement <input type="checkbox"/> Other		__/__/____	<input type="checkbox"/> Soreness around injection site <input type="checkbox"/> Fever <input type="checkbox"/> Other	<input type="checkbox"/> Upper arm <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Thigh <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Buttocks <input type="checkbox"/> Other, describe_____
<input type="checkbox"/> Routine childhood vaccination <input type="checkbox"/> Flu shot <input type="checkbox"/> Antibiotic <input type="checkbox"/> Steroid <input type="checkbox"/> Other medication <input type="checkbox"/> Allergy shot <input type="checkbox"/> Vitamin/supplement <input type="checkbox"/> Other		__/__/____	<input type="checkbox"/> Soreness around injection site <input type="checkbox"/> Fever <input type="checkbox"/> Other	<input type="checkbox"/> Upper arm <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Thigh <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Buttocks <input type="checkbox"/> Other, describe_____
<input type="checkbox"/> Routine childhood vaccination <input type="checkbox"/> Flu shot <input type="checkbox"/> Antibiotic <input type="checkbox"/> Steroid <input type="checkbox"/> Other medication <input type="checkbox"/> Allergy shot <input type="checkbox"/> Vitamin/supplement <input type="checkbox"/> Other		__/__/____	<input type="checkbox"/> Soreness around injection site <input type="checkbox"/> Fever <input type="checkbox"/> Other	<input type="checkbox"/> Upper arm <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Thigh <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Buttocks <input type="checkbox"/> Other, describe_____

**28. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure)		____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion <input type="checkbox"/> Sore throat		____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains		____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth		____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other Please specify _____		____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No

**29. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure)		_____days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion <input type="checkbox"/> Sore throat		_____days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains		_____days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth		_____days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other Please specify _____		_____days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No

**30. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure) Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion? Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth <input type="checkbox"/> Other. Please specify _____	_____days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> AFM patient did not have any illness before limb weakness <input type="checkbox"/> Before <input type="checkbox"/> After <input type="checkbox"/> Same time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure) Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion? Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth <input type="checkbox"/> Other. Please specify _____	_____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> AFM patient did not have any illness before limb weakness <input type="checkbox"/> Before <input type="checkbox"/> After <input type="checkbox"/> Same time <input type="checkbox"/> Don't know
Household member #3 (Relationship and age)	Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure) Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion? Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth <input type="checkbox"/> Other. Please specify _____	_____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> AFM patient did not have any illness before limb weakness <input type="checkbox"/> Before <input type="checkbox"/> After <input type="checkbox"/> Same time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ days	<input type="checkbox"/> Yes,	<input type="checkbox"/> AFM patient did not have any illness



(Relationship and age)	<input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure) Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion? Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth <input type="checkbox"/> Other. Please specify _____	<input type="checkbox"/> Don't know	_____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	before limb weakness <input type="checkbox"/> Before <input type="checkbox"/> After <input type="checkbox"/> Same time <input type="checkbox"/> Don't know
Household member #5 (Relationship and age)	Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the highest measured? _____ <input type="checkbox"/> Subjective (d/n measure) Cold symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cough <input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion? Gastrointestinal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pains Rashes/Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rash/sores on the palms <input type="checkbox"/> Rash/sores on the soles of the feet <input type="checkbox"/> Rash/sores in the diaper/underwear region <input type="checkbox"/> Sores in the mouth <input type="checkbox"/> Other. Please specify _____	_____ days <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> AFM patient did not have any illness before limb weakness <input type="checkbox"/> Before <input type="checkbox"/> After <input type="checkbox"/> Same time <input type="checkbox"/> 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
<b>Where was [name] seen?</b>	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Emergency room <input type="checkbox"/> Other, describe _____	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Emergency room <input type="checkbox"/> Other, describe _____	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Emergency room <input type="checkbox"/> Other, describe _____	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Emergency room <input type="checkbox"/> Other, describe _____
<b>Why did you take [name] to the doctor?</b>				
<b>Number of days before or after limb weakness onset of limb weakness</b>				
<b>Who saw [name]?</b>	<input type="checkbox"/> Nurse <input type="checkbox"/> Doctor (Ped/FP) <input type="checkbox"/> Specialist, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Nurse <input type="checkbox"/> Doctor (Ped/FP) <input type="checkbox"/> Specialist, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Nurse <input type="checkbox"/> Doctor (Ped/FP) <input type="checkbox"/> Specialist, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Nurse <input type="checkbox"/> Doctor (Ped/FP) <input type="checkbox"/> Specialist, specify _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Don't know
<b>Did [name] receive a diagnosis?</b>	<input type="checkbox"/> Yes, specify _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, specify _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, specify _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes, specify _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

	Visit 1	Visit 2	Visit 3	Visit 4
Did the doctor recommend any medications or treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
What medications were given/prescribed?	<input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other _____	<input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other _____	<input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other _____	<input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other _____
Did the medications result in any improvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Did the doctor decide to admit [name] to the hospital on this visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> Antibiotic <input type="checkbox"/> Insulin <input type="checkbox"/> ADHD med <input type="checkbox"/> OTC pain med/fever reducer <input type="checkbox"/> OTC cold/cough <input type="checkbox"/> Herbal or homeopathic remedies <input type="checkbox"/> Vitamins or nutritional supplements <input type="checkbox"/> Topical treatments <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Inhaler <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed <input type="checkbox"/> One time prescription

Medication (name)	Type of medication	Method of administration	Frequency
	<input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> Antibiotic <input type="checkbox"/> Insulin <input type="checkbox"/> ADHD med <input type="checkbox"/> OTC pain med/fever reducer <input type="checkbox"/> OTC cold/cough <input type="checkbox"/> Herbal or homeopathic remedies <input type="checkbox"/> Vitamins or nutritional supplements <input type="checkbox"/> Topical treatments <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Inhaler <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed <input type="checkbox"/> One time prescription
	<input type="checkbox"/> Steroid/prednisone <input type="checkbox"/> Antibiotic <input type="checkbox"/> Insulin <input type="checkbox"/> ADHD med <input type="checkbox"/> OTC pain med/fever reducer <input type="checkbox"/> OTC cold/cough <input type="checkbox"/> Herbal or homeopathic remedies <input type="checkbox"/> Vitamins or nutritional supplements <input type="checkbox"/> Topical treatments <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Inhaler <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	<input type="checkbox"/> On a regular basis <input type="checkbox"/> As needed <input type="checkbox"/> 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)**

<input type="checkbox"/> Kosher <input type="checkbox"/> Low carb <input type="checkbox"/> Dairy-free <input type="checkbox"/> Other, please describe: _____	<input type="checkbox"/> Halal <input type="checkbox"/> Paleo (high protein, low carb) <input type="checkbox"/> Gluten-free	<input type="checkbox"/> Raw foods <input type="checkbox"/> Vegetarian/Vegan <input type="checkbox"/> Weight loss/low fat
---	---	---

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

Public pool

Splash pad

Lake/River

Private residence pool

Other \_\_\_\_\_

Beach

Don't know

No

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

Camping

Fishing

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

Amusement park

Hiking

Don't know

Gardening/raking/moving/digging in soil

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

No

Playing in sandbox

Going to a farm/petting zoo

## 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?
	____/____/____ <input type="checkbox"/> Don't know	____/____/____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Personal vehicle <input type="checkbox"/> Airplane <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Other, describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If yes, describe: _____
	____/____/____ <input type="checkbox"/> Don't know	____/____/____ <input type="checkbox"/> Don't know	<input type="checkbox"/> Personal vehicle <input type="checkbox"/> Airplane <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Other, describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 smelting, 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 smelting, 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
- Solvents



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>