…………………………………………………………………………………………………………………………………

**Interviewee Information**

Booking or JDE Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specimen ID

First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: / / (MM/DD/YYYY)

CDC ID\_\_\_\_\_\_\_\_\_\_

## **Administrative Information**

1. Interviewer Name: First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /
2. Housing [*detainee*] or work [*staff*] location: Division: \_\_\_\_\_\_ Unit: \_\_\_\_\_\_ Tier:\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
3. At the unit, the number of current: Staff present:\_\_\_\_\_\_ Cells:\_\_\_\_\_\_\_\_\_\_\_\_ Detainees:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Interviewee:  Detainee  Staff

## **Demographic Information**

1. Age: \_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_ (ft, in) Weight: \_\_\_\_\_\_\_ (lbs)
2. Ethnicity (select one):  Hispanic/Latino  Non-Hispanic/Latino  Not Specified
3. Race (check all that apply):  White  Black  Asian  Am Indian/Alaska Nat  Nat Hawaiian/Other PI  Other, specify:\_\_\_\_\_\_\_\_\_\_\_  Unknown
4. Sex:  Male  Female

**Symptoms**

1. *Use no touch thermometer to record current temperature*: \_\_\_\_\_\_\_\_°F
2. In the last two weeks, have you experienced any of the following symptoms*? [If symptoms are still ongoing, mark the checkbox and leave the second date blank]*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Symptom Present ? | Onset Date  (mm/dd) | End Date/Ongoing  (mm/dd) |
| Fever >100.4F (38C)c | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Subjective fever (felt feverish, or hot/sweaty) | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Chills | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Muscle aches (myalgia) | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Runny nose (rhinorrhea) | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Nasal congestion | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Sore throat | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Cough (new onset or worsening of chronic cough) | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Shortness of breath (dyspnea) | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Abdominal pain | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Diarrhea (≥3 loose/looser than normal stools/24hr period) | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Nausea | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Vomiting | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Headache | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Loss of taste  Complete  Partial | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Loss of smell  Complete  Partial | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |
| Other, specify: | Yes No Unk | \_\_\_/\_\_\_ | \_\_\_/\_\_\_ Ongoing |

**Smoking Status** *Note: Smoking is prohibited in the facility compound for all detainees.*

1. [*Staff only*] Do you currently smoke tobacco on a daily basis, less than daily, or not at all?

Daily  Less than daily  Not at all  Unknown

1. [*Staff only*] Do you currently vape or use electronic cigarettes on a daily basis, less than daily, or not at all?

Daily  Less than daily  Not at all  Unknown

1. In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?

Daily  Less than daily  Not at all  Unknown

1. [*If any use*] When was the last time you used tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)
2. In the past, have you vaped or used electronic cigarettes on a daily basis, less than daily, or not at all?

Daily  Less than daily  Not at all  Unknown

1. [*If any use*] When was the last time you used electronic cigarettes or vaping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

## **Past Medical History**

1. Please provide pre-existing medical conditions (complete regardless of age):

|  |  |  |
| --- | --- | --- |
| Condition | Response | If YES, specify |
| Health conditions that cause breathing problems? | Yes No  Unknown | Emphysema  Lung Cancer  Asthma  Sleep Apnea  COPD (chronic obstructive pulmonary disease)  Other, specify:\_\_\_\_\_\_\_\_\_\_ |
| Diabetes or problems with your blood sugar? | Yes No  Unknown | Type 1  Type 2  Are you taking insulin? Yes No Unk |
| Heart problems or high blood pressure | Yes No  Unknown | Coronary artery disease)  Hyperlipidemia (high cholesterol)  Heart failure  Congenital heart abnormalities  Hypertension/High blood pressure  Myocardial infarction/heart attack Other, specify\_\_\_\_\_ |
| Kidney problem | Yes No  Unknown | Requires dialysis  End stage renal disease)  Chronic kidney disease  Other, specify: \_\_\_\_\_\_\_\_ |
| Liver problems | Yes No  Unknown | Cirrhosis/ End stage liver disease  Hepatitis B  Hepatitis C Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| A disease, medication or condition that weakens your immune system? | Yes No  Unknown | HIV/AIDS  Lupus  Steroids  Chemotherapy  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Learning or memory problems or history of head injury? | Yes No  Unknown | Stroke  Dementia/Alzheimer’s  Traumatic brain injury  Neuro Development disorder Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have other health/medical problems you would like me to know about? | Yes No  Unknown | Specify: |

**Facility Questions**

1. At this facility, how many different people are you in contact with (<6 ft) on an average day?\_\_\_\_\_\_\_\_\_\_
2. In the last two weeks, have you [*had handcuffs put on / placed handcuffs on a detainee*]?

Yes  No  Unknown

* 1. If yes, how many times per day (1 time would be once per day having them put on and taken off)? \_\_\_\_\_

**Sanitation levels**

1. How many times per day do you wash or sanitize your hands (on average)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When you wash your hands, do you use (check all that apply):  Soap  Hand sanitizer  Water

Don’t wash hands  Unknown

1. When do you wash your hands (check all that apply)?  Before eating  After touching a shared phone

After coughing or sneezing  After touching another person  After using the bathroom  After touching dirty laundry  After working  Never  Unknown

1. Have you worn a mask at the facility in the last 2-weeks?  Yes  No  Unknown
   1. If yes, what type of mask (check all that apply)?  Cloth  Surgical  Unknown

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

* 1. When around others (<6 ft), how often do you wear a mask?  Always  Sometimes

Occasionally  Never  Unknown

* 1. When outside of your cell, how often do you wear a mask?  Always  Sometimes

Occasionally  Never  Unknown

**Movement and Activity History**

1. While in this facility, have you done any of the following activities in the last two weeks?

|  |  |  |
| --- | --- | --- |
| Activity | Answer | Frequency |
| …shaken hands with a person? | Yes  No | Daily  A few times a week  Once a week |
| …played cards or a game with a person? | Yes  No | Daily  A few times a week  Once a week |
| …used a phone that is shared with others? | Yes  No | Daily  A few times a week  Once a week |
| …used a computer that is shared with others? | Yes  No | Daily  A few times a week  Once a week |
| …shared items with a person? (cards, checkers, remote control, basketball, pen, pencil, dominos, etc) | Yes  No | Daily  A few times a week  Once a week |
| …exercised, worked out, or played sports with a person? | Yes  No | Daily  A few times a week  Once a week |
| …slept in the same cell/room as a person? | Yes  No | Daily  A few times a week  Once a week |
| …shared a cigarette or vape pen with a person? | Yes  No | Daily  A few times a week  Once a week |
| …shared a plate, utensil, or drinking cup/glass with a person? | Yes  No | Daily  A few times a week  Once a week |
| …used a bathroom that is shared with others? | Yes  No | Daily  A few times a week  Once a week |
| …traveled in the same vehicle (car, bus), sitting within 6 feet of a person? | Yes  No | Daily  A few times a week  Once a week |
| …gone to court? | Yes  No | Daily  A few times a week  Once a week |
| …[*detainee only*] had a work assignment off your tier? | Yes  No | Daily  A few times a week  Once a week |

**Potential Exposure**

1. In the last two weeks have you been around any people who appear to be sick and have COVID-19 symptoms, such as a fever, cough, or shortness of breath?

Yes  No  Unknown (*If yes,* how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

## **SARS-CoV-2 testing**

1. Have you ever been offered a test for coronavirus?  Yes  No  Refused  Unknown
   1. If yes, have you been tested for coronavirus?  Yes  No
      1. Date of most recent test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)
      2. Were you experiencing symptoms when you were tested?  Yes  No
      3. Result of most recent test:  Positive  Negative  Pending  Indeterminate  Don’t know/other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_