



SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

CDC ID: _____

.....
Interviewee Information

Booking or JDE Number: _____

Specimen ID

First: _____ Last: _____

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

CDC ID _____

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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

5. Age: _____ Height: _____ (ft, in) Weight: _____ (lbs)
6. Ethnicity (select one): Hispanic/Latino Non-Hispanic/Latino Not Specified
7. Race (check all that apply): White Black Asian Am Indian/Alaska Nat Nat Hawaiian/Other PI
 Other, specify: _____ Unknown
8. Sex: Male Female

Symptoms

9. Use no touch thermometer to record current temperature: _____ °F
10. 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Subjective fever (felt feverish, or hot/sweaty)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Nasal congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	___/___	___/___ <input type="checkbox"/> Ongoing

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

11. [*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
12. [*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
13. 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
14. [*If any use*] When was the last time you used tobacco? _____ (MM/DD/YYYY)
15. 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



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

Past Medical History

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

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

Facility Questions

18. At this facility, how many different people are you in contact with (<6 ft) on an average day? _____

19. In the last two weeks, have you [had handcuffs put on / placed handcuffs on a detainee]?

Yes No Unknown

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

Sanitation levels

20. How many times per day do you wash or sanitize your hands (on average)? _____

21. When you wash your hands, do you use (check all that apply): Soap Hand sanitizer Water
 Don't wash hands Unknown

22. 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

23. Have you worn a mask at the facility in the last 2-weeks? Yes No Unknown

a. If yes, what type of mask (check all that apply)? Cloth Surgical Unknown

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).



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- Other, specify: _____
- b. When around others (<6 ft), how often do you wear a mask? Always Sometimes
 Occasionally Never Unknown
- c. When outside of your cell, how often do you wear a mask? Always Sometimes
 Occasionally Never Unknown

Movement and Activity History

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

Potential Exposure

25. 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? _____)

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SARS-CoV-2 testing

26. Have you ever been offered a test for coronavirus? Yes No Refused Unknown

a. If yes, have you been tested for coronavirus? Yes No

i. Date of most recent test: _____(MM/DD/YYYY)

ii. Were you experiencing symptoms when you were tested? Yes No

iii. Result of most recent test: Positive Negative Pending Indeterminate
Don't know/other _____