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

**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

**Symptoms**

1. *Use no touch thermometer to record current temperature*: \_\_\_\_\_\_\_\_°F
2. Since we last visited you, 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 |

**Potential Exposure**

1. Since we last visited you, 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)