



SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020
(Correctional Facility Transmission Investigation)
Day 3/4 Form

CDC ID: _____

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Interviewee Information

Booking or JDE Number: _____

Specimen ID

First: _____ Last: _____

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

CDC ID _____



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 (Correctional Facility Transmission Investigation)
Day 3/4 Form

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

5. Use no touch thermometer to record current temperature: _____°F
6. 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	<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

Potential Exposure

7. 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? _____)