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**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 2Are 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_