Form Approved. OMB No. 0920-1011 Exp. 08/02/2020

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]	☐ 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.*

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?	☐ 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

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

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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?	☐ 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

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 _______________

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