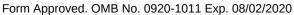


#### Form Approved. OMB No. 0920-1011 Exp. 08/02/2020

# 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	



CDC ID:

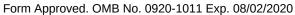


# SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020

(Correctional Facility Transmission Investigation) **Day 0/1 Form** 

Administrative Information				
1. Interviewer Name: First:Last:		_ Date:	/	
2. Housing [detainee] or work [staff] location: Division: _	Unit: Tier	: Other	<b>:</b>	
3. At the unit, the number of current: Staff present:	Cells: De	tainees:		
4. Interviewee: Detainee Staff				
D It for a				
Demographic Information	.1. (11.)			
5. Age: Height: (ft, in) Weighties. Ethnicity (select one): Hispanic/Latino N	gnt: (IDS)	N-4 C:6:	1	
6. Ethnicity (select one): Hispanic/Latino N	on-Hispanic/Latino	Not Specified	] [-+ ]]::/O+] DI	
7. Race (check all that apply): White Black Other, specify:		aska ivat iv	iat Hawaiian/Other Pi	
8. Sex: Male Female				
o. Sex. Ividie 1 emale				
Symptoms				
9. Use no touch thermometer to record current temperature	e:°F			
10. In the last two weeks, have you experienced any of the		f symptoms are	still ongoing, mark	
the checkbox and leave the second date blank]				
	Symptom Present ?	Onset Date	End Date/Ongoing	
		(mm/dd)	(mm/dd)	
Fever >100.4F (38C) <sup>c</sup>	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 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	
<b>Smoking Status</b> <i>Note: Smoking is prohibited in the facility</i>				
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. [ <i>Staff only</i> ] Do you <u>currently vape or use electronic cigarettes</u> 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. [ <i>If any use</i> ] 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_				

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).



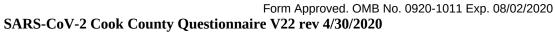


# SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020

(Correctional Facility Transmission Investigation) **Day 0/1 Form** 

16. [ <i>If any use</i> ] When was the last time you used electronic cigarettes or vaping? (MM/DD/YYYY)					
<ul><li><u>Past Medical History</u></li><li>17. Please provide pre-existing medical conditions (complete regardless of age):</li></ul>					
Condition		If YES, specify			
Health conditions that cause	Response Yes No				
breathing problems?	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:			
19. In the last two weeks, have you Yes No Unknown	[had handcuffs put on / ] own	ontact with (<6 ft) on an average day? placed handcuffs on a detainee]? ald be once per day having them put on and taken off)?			
Sanitation levels  20. How many times per day do yo 21. When you wash your hands, do	•				
22. When do you wash your hands  After coughing or sneezing dirty laundry  After worki	After touching anot	☐ Before eating ☐ After touching a shared phone her person ☐ After using the bathroom ☐ After touching Jnknown			
23. Have you worn a mask at the fa a. If yes, what type of	cility in the last 2-weeks mask (check all that app				

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(Correctional Facility Transmission Investigation)

#### Day 0/1 Form

Other, specify:				
b. When around others (<6 ft), how often do you wear a mask? Always Sometimes				
Occasionally Unknown				
c. When outside of your cell, how ofte	n do you wear a m Unknown	ask?  Always  Sometimes		
Occasionally ivever				
Movement and Activity History				
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,	Yes No	Daily A few times a week Once a week		
remote control, basketball, pen, pencil, dominos,				
etc)				
exercised, worked out, or played sports with a	Yes No	Daily A few times a week Once a week		
person?				
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	Yes No	Daily A few times a week Once a week		
with a person?				
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	Yes No	Daily A few times a week Once a week		
within 6 feet of a person?				
gone to court?	Yes No	Daily A few times a week Once a week		
[detainee only] had a work assignment off	Yes No	Daily A few times a week Once a week		
your tier?				
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 ( <i>If yes</i> , how many?)				

**CDC ID:** \_\_\_\_\_



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

CDC ID.

# SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020

(Correctional Facility Transmission Investigation) **Day 0/1 Form** 

		CDC ID:
SARS-CoV-2 testing 6. Have you ever been off	fered a test for coronavirus?  Yes No Refused	Unknown
a. If yes, have	e you been tested for coronavirus?  Yes No	
i. Da	ate of most recent test:	_(MM/DD/YYYY)
ii. We	ere you experiencing symptoms when you were tested?	Yes No
	esult of most recent test: Positive Negative on't know/other	Pending Indeterminate