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 3/4 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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SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020
(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]	☐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

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? _____)