



SARS-CoV-2 Cook County Questionnaire V22 rev 4/30/2020
(Correctional Facility Transmission Investigation)
Day 14 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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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. 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	<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

Facility Questions (these questions are about a typical day in the last two weeks)

7. At this facility, how many different people are you in contact with (<6 ft) on an average day? _____
8. 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

9. How many times per day do you wash or sanitize your hands (on average)? _____
10. When you wash your hands, do you use (check all that apply): Soap Hand sanitizer Water
 Don't wash hands Unknown
11. 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
12. 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
 Other, specify: _____
 b. When around others (<6 ft), how often do you wear a mask? Always Sometimes
 Occasionally Never Unknown



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- c. When outside of your cell, how often do you wear a mask? [] Always [] Sometimes [] Occasionally [] Never [] Unknown

Movement and Activity History

13. While in this facility, have you done any of the following activities in the last two weeks?

Table with 3 columns: Activity, Answer (Yes/No), and Frequency (Daily/A few times a week/Once a week). Rows include activities like shaking hands, playing cards, using shared devices, etc.

Potential Exposure

14. 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

15. 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



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- iii. Result of most recent test: Positive Negative Pending Indeterminate
Don't know/other _____