…………………………………………………………………………………………………………………………………

**Interviewee Information**

Booking or JDE Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specimen ID

First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: / / (MM/DD/YYYY)

CDC ID\_\_\_\_\_\_\_\_\_\_

**NOTE: This page is for paper records only. Do not scan for data entry into the electronic database.**

## **Administrative Information**

1. Interviewer Name: First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /
2. Housing location: Dorm: \_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Sleeping location: [ ]  top bunk [ ]  bottom bunk
4. Date quarantine initiated in dorm: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
5. At the dorm, the number of current: Staff present:\_\_\_\_\_\_\_\_\_ Cells:\_\_\_\_\_\_\_\_\_\_\_\_ Detainees:\_\_\_\_\_\_\_\_\_\_\_\_

## **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*?*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Symptom Present Last 2 Weeks? | Onset Date(mm/dd) | # of Days | Ongoing? | Last 2 Months? |
| Fever >100.4°F (38° C) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Subjective fever (felt feverish, or hot/sweaty) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Chills | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Muscle aches (myalgia) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Runny nose (rhinorrhea) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Stuffy nose (nasal congestion) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Sore throat | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Cough (new onset or worsening of chronic cough) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Shortness of breath (dyspnea) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Abdominal pain  | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Diarrhea (≥3 loose stools/24hr period) | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Nausea | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Vomiting | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Headache | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Loss of taste [ ]  Complete [ ]  Partial  | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Loss of smell [ ]  Complete [ ]  Partial  | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |
| Other, specify: | [ ] Yes [ ] No [ ] Unk | \_\_\_/\_\_\_ |  | [ ]  | [ ]  |

NOTE: For any of these symptoms, have you experienced them in the last two months? That means since \_\_\_\_\_\_(month).

**Smoking Status** *Note: Smoking is prohibited in the facility compound for all detainees.*

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/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/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 [ ] Unk/DK/Ref | [ ]  Asthma [ ]  COPD (chronic obstructive pulmonary disease) [ ]  Emphysema [ ]  Lung Cancer [ ]  Sleep Apnea [ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diabetes or problems with your blood sugar? | [ ] Yes [ ] No [ ] Unk/DK/Ref | [ ]  Type 1 [ ]  Type 2Are you taking insulin? [ ]  Yes [ ]  No  |
| Heart problems or high blood pressure?  | [ ] Yes [ ] No [ ] Unk/DK/Ref | [ ]  Congenital heart abnormalities [ ]  Coronary artery disease [ ]  Heart failure [ ]  High cholesterol (Hyperlipidemia) [ ]  High blood pressure (Hypertension)[ ]  Heart attack (Myocardial infarction) [ ]  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Kidney problems?  | [ ] Yes [ ] No [ ] Unk/DK/Ref | [ ]  Chronic kidney disease [ ]  Dialysis [ ]  End-stage renal disease [ ]  Other, specify: \_\_\_\_\_\_\_\_ |
| Liver problems?  | [ ] Yes [ ] No [ ] Unk/DK/Ref | [ ]  Cirrhosis [ ]  End-stage liver disease [ ]  Hepatitis B [ ]  Hepatitis C [ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_\_ |
| A disease, medication, or condition that weakens your immune system? | [ ] Yes [ ] No [ ] Unk/DK/Ref | [ ]  Chemotherapy [ ]  HIV/AIDS [ ]  Lupus [ ]  Steroids [ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Learning or memory problems or history of head injury? | [ ] Yes [ ] No [ ] Unk/DK/Ref | [ ]  Dementia/Alzheimer’s [ ]  Neurodevelopmental Disorder [ ]  Stroke [ ]  Traumatic Brain Injury [ ]  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have other health/medical problems you would like me to know about?  | [ ] Yes [ ] No [ ] Unk/DK/Ref | Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medication Use**

1. **Currently,** what types of medications do you take for underlying conditions, including prescriptions & inhalers?

Do you take any medications for high blood pressure?

How about for infections caused by fungus, bacteria, or viruses? *(If yes, ask questions to fill in table below)*

How about any medications that may weaken your immune system and ability to fight infections? These medications are often used to treat autoimmune disorders or inflammation. *(If yes, ask questions to fill in table below)*

Do you use an inhaler? *(If yes, ask questions to fill in table below)*

Any other medications you may have forgotten? *(If yes, ask questions to fill in table below)*

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Route | Frequency | Indication |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**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? *(\*Other than for this survey\*)*

[ ]  Yes [ ]  No [ ]  Unknown

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 & Water [ ]  Hand sanitizer [ ]  Water alone

 [ ]  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 [ ]  Usually [ ]  Sometimes [ ]  Never [ ]  Unknown

* 1. When outside of your cell, how often do you wear a mask?

 [ ]  Always [ ]  Usually [ ]  Sometimes [ ]  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? (Excludes video court) | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |
| …had a work assignment off your dorm? | [ ]  Yes [ ]  No  | [ ]  Daily [ ]  A few times a week [ ]  Once a week  |

1. Have you been assigned to any other dorms in the last 2 months? [ ]  Yes [ ]  No
	1. If yes, how many? \_\_\_\_\_\_\_\_\_
	2. If known, specify dorm(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Potential Exposure**

1. In the last two weeks, have you been around any people who appear to be sick with 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. Did you experience any symptoms at the time you were tested? [ ]  Yes [ ]  No
		3. Result of most recent test: [ ]  Positive [ ]  Negative [ ]  Pending [ ]  Indeterminate [ ]  Don’t know

[ ]  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_