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

**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 2  Are 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_