



**SARS-CoV-2 Louisiana Questionnaire V1 rev 05/04/2020**  
(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 \_\_\_\_\_

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



SARS-CoV-2 Louisiana Questionnaire V1 rev 05/04/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

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

Administrative Information

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

Demographic Information

- 4. Age: \_\_\_\_\_ Height: \_\_\_\_\_ (ft, in) Weight: \_\_\_\_\_ (lbs)
5. Ethnicity (select one): [ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Not Specified
6. Race (check all that apply): [ ] White [ ] Black [ ] Asian [ ] Am Indian/Alaska Nat [ ] Nat Hawaiian/Other PI
[ ] Other, specify: \_\_\_\_\_ [ ] Unknown
7. Sex: [ ] Male [ ] Female

Symptoms

- 8. Use no-touch thermometer to record current temperature: \_\_\_\_\_ °F
9. In the last two weeks, have you experienced any of the following symptoms?

Table with 6 columns: Symptom, Symptom Present Last 2 Weeks?, Onset Date (mm/dd), # of Days, Ongoing?, Last 2 Months?. Rows include symptoms like Fever, Chills, Muscle aches, Runny nose, Stuffy nose, Sore throat, Cough, Shortness of breath, Abdominal pain, Diarrhea, Nausea, Vomiting, Headache, Loss of taste, Loss of smell, and Other, specify.

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.

- 10. 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
11. [If any use] When was the last time you used tobacco? \_\_\_\_\_ (MM/YYYY)
12. 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 Louisiana Questionnaire V1 rev 05/04/2020**  
 (Correctional Facility Transmission Investigation)  
**Day 0/1 Form**

**CDC ID:** \_\_\_\_\_  
 (MM/YYYY)

13. [If any use] When was the last time you used electronic cigarettes or vaping? \_\_\_\_\_

**Past Medical History**

14. Please provide pre-existing medical conditions (complete regardless of age):

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

**Medication Use**

15. **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
-----------------	-------	-----------	------------



SARS-CoV-2 Louisiana Questionnaire V1 rev 05/04/2020
(Correctional Facility Transmission Investigation)
Day 0/1 Form

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

Table with 4 columns and 3 rows. Columns contain checkboxes for medication routes (PO, Topical, Other, Injection, Inhaled) and frequencies (QD, BID, TID, QOD, Unknown, Other).

Facility Questions

- 16. At this facility, how many different people are you in contact with (<6 ft) on an average day?
17. 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

- 18. How many times per day do you wash or sanitize your hands (on average)?
19. When you wash your hands, do you use (check all that apply): Soap & Water Hand sanitizer Water alone Don't wash hands Unknown
20. 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
21. 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 Usually Sometimes Never Unknown
c. When outside of your cell, how often do you wear a mask? Always Usually Sometimes Never Unknown

Movement and Activity History

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

Table with 3 columns: Activity, Answer, Frequency. Rows include activities like shaken hands, playing cards, using shared phone/computer, and sharing items.

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.



**SARS-CoV-2 Louisiana Questionnaire V1 rev 05/04/2020**  
(Correctional Facility Transmission Investigation)

**Day 0/1 Form**

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

etc)		
...exercised, worked out, or played sports with a person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...slept in the same cell/room as a person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...shared a cigarette or vape pen with a person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...shared a plate, utensil, or drinking cup/glass with a person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...used a bathroom that is shared with others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...traveled in the same vehicle (car, bus), sitting within 6 feet of a person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...gone to court? (Excludes video court)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week
...had a work assignment off your dorm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> A few times a week <input type="checkbox"/> Once a week

23. Have you been assigned to any other dorms in the last 2 months?  Yes  No

a. If yes, how many? \_\_\_\_\_

b. If known, specify dorm(s): \_\_\_\_\_

**Potential Exposure**

24. 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**

25. 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. Did you experience any symptoms at the time you were tested?  Yes  No

iii. Result of most recent test:  Positive  Negative  Pending  Indeterminate  Don't know  
 Other, specify: \_\_\_\_\_