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**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. At the dorm, the number of current: Staff present:\_\_\_\_\_\_ Cells:\_\_\_\_\_\_\_\_\_\_\_\_ Detainees:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

1. *Use no touch thermometer to record current temperature*: \_\_\_\_\_\_\_\_°F
2. Since we last visited you, have you experienced any of the following symptoms*?*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Symptom Present Since Last Visit? | Onset Date(mm/dd) | # of Days | Ongoing? |
| 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 | \_\_\_/\_\_\_ |  | [ ]  |

**Potential Exposure**

1. Since we last visited you, 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)