

SHIGELLA HYPOTHESIS GENERATING QUESTIONNAIRE

The Centers of Disease Control and Prevention, in collaboration with your local health department, are collecting information about people who were recently sick with a *Shigella* infection, also called shigellosis. *Shigella* are a group of bacteria that cause diarrheal illness. We are trying to determine how you (or the ill person) became sick with a *Shigella* infection. The information we are collecting in this questionnaire will also help prevent others from getting sick.

You may have already been contacted by the health department. We would like to ask you a few additional questions about your (or the ill person's) recent illness and about any exposures you (or the ill person) may have had before becoming ill. Your help in the investigation is very important. Your participation is voluntary, and you may refuse to answer any question at any time. All information will be kept confidential to the extent permitted by law. No names or other identifying information will be used in any reports.

This questionnaire will likely take no more than 45 minutes. Are you willing to participate?

- **Yes (If yes: You have selected to participate in this survey. Move to the next page to begin the survey.)**
- **No (If no: You have selected not to participate in this survey. We appreciate your time. Move to the next page in order to end the survey and submit your response. For more information about shigellosis please go to) www.cdc.gov/shigella/**

Section 1: INTERVIEW INFORMATION

1. Are you completing this interview on behalf of yourself or another person?
 - a. Self
 - b. Another Person

2. What best describes your relationship to the other person?
 - a. Spouse
 - b. Child
 - c. Other dependent
 - d. Other
 - l. (specify): _____

For the following questions please fill in the questionnaire with information on the person sick with shigellosis. If you are taking the survey for another person, answer all questions according to information about the person sick with shigellosis. If you are taking the survey on behalf of yourself, please answer all questions according to information about yourself.

Section 2: CASE INFORMATION

1. What is your (or the ill person's) state of residence: _____	2. What is your (or the ill person's) county of residence: _____
3. What is the age of the person sick with shigellosis: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	
4. What sex were you (or the ill person) assigned at birth? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
5. How do you describe your (or the ill person's) ethnicity? <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
6. How do you describe your (or the ill person's) race? (select all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused	
7. [If case indicates they're ≥14 years old], what is your (or the ill person's) current occupation? _____	

Section 3: HOUSEHOLD INFORMATION

1. What would best describe the type of housing you (or the ill person) currently live in? For example, a house, apartment, or mobile home. <input type="checkbox"/> House/single family home <input type="checkbox"/> Apartment <input type="checkbox"/> Hotel/motel <input type="checkbox"/> Long term care facility <input type="checkbox"/> Nursing home/assisted living facility <input type="checkbox"/> Mobile home <input type="checkbox"/> Shelter <input type="checkbox"/> Rehabilitation center <input type="checkbox"/> Half-way house <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
2. In the <u>past 30 days</u> , did you (or the ill person) double up or stay overnight with friends, relatives, or someone you didn't know well because you didn't have a regular place to stay at night? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown
3. In the <u>past 30 days</u> , were you (or the ill person) ever homeless? That is, were you living on the street, in a shelter, in a single room occupancy hotel, or in a car? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown
4. What is the water source at your (or the ill person's) primary place of residence? <input type="checkbox"/> Municipal <input type="checkbox"/> Well <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
5. What is the sewer connection at your (or the ill person's) primary place of residence? <input type="checkbox"/> Municipal <input type="checkbox"/> Septic tank <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
6. How many people, including you (or the ill person), live in your (or the ill person's) primary place of residence? _____ <input type="checkbox"/> Unknown a. Do any of these people (either children or adults) wear diapers? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown b. How many people living in your (or the ill person's) household are under the age of 5? _____ <input type="checkbox"/> click here if unknown number of people under the age of 5
7. What was your (or the ill person's) household income last year from all sources before taxes? <i>That is, the total amount of money earned and shared by all people living in your household.</i> <input type="checkbox"/> <\$20,000 <input type="checkbox"/> \$20,000-\$39,999 <input type="checkbox"/> \$40,000-\$59,999 <input type="checkbox"/> \$60,000-\$79,999 <input type="checkbox"/> \$80,000-99,999 <input type="checkbox"/> \$100,000 or more <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown

Section 4: CLINICAL INFORMATION

1. What date did you (or the ill person) first feel sick? _____ / _____ / _____ <input type="checkbox"/> Approximate date <input type="checkbox"/> Unknown Month / Day / Year
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2. What date did you (or the ill person) stop feeling sick? ____/____/____ Approximate date Unknown Ongoing
 Month / Day / Year

a. If unsure of specific dates in questions 1 and 2, about how many days were you (or the ill person) sick? _____

Yes	No	Don't Know	3. Have you (or the ill person) had any of the following symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Diarrhea (at least 3 loose, watery stools in 24 hours)
			i. About how many days did you (or the ill person) have diarrhea? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Abdominal pain/cramps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Bloody stools/bloody diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Achy joints/muscles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Tenesmus (or feeling the need to pass stool [poop] even when bowels are empty)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Other symptoms I didn't ask about (specify): _____

Section 5: MEDICAL CARE AND TREATMENT INFORMATION

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. As a result of your (or the ill person's) illness, did you (or the ill person) seek medical care?
			a. [If yes to question 1] Where did you (or the ill person) seek medical care? (select all that apply) <input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Pharmacy clinic <input type="checkbox"/> STD clinic <input type="checkbox"/> Emergency department <input type="checkbox"/> Hospital <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Were you (or the ill person) admitted to a hospital overnight?
			i. [If yes to question 1b] For how many nights were you (or the ill person) hospitalized? _____ <input type="checkbox"/> click here is unknown number of nights hospitalized
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. [If yes to question 1b] Were you (or the ill person) admitted to the intensive care unit?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In addition to infection with <i>Shigella</i> , did your (or the ill person's) doctor tell you that you were sick with any other infection(s)?
			a. [If yes to question 2] What was the name of the other infection(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Were you (or was the ill person) prescribed any antibiotics for this illness?
			a. [If yes to question 3] What was the name of the antibiotic(s), dose, and frequency? _____ <input type="checkbox"/> Don't know
			b. [If yes to question 3] Which date did you (or the ill person) start taking the antibiotic(s)? ____/____/____ <input type="checkbox"/> Approximate date <input type="checkbox"/> Unknown Month / Day / Year
			c. [If yes to question 3] Which date did you (or the ill person) stop taking the antibiotic(s)? ____/____/____ <input type="checkbox"/> Approximate date <input type="checkbox"/> Unknown <input type="checkbox"/> Still taking antibiotic(s) Month / Day / Year
			d. [If yes to question 3] In the 24 hours after taking the antibiotic(s), did your (or the ill person's) symptoms

Section 6: EXPOSURE INFORMATION

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the <u>7 days before</u> your illness started, did you (or the ill person) spend any time outside of your home state?
			a. [If yes to question 1] List all U.S. states where you (or the ill person) traveled: _____
			i. List dates of domestic travel: _____ <input type="checkbox"/> Did not travel domestically
			ii. What was the purpose of this travel? (select all that apply) <input type="checkbox"/> Tourism <input type="checkbox"/> Work <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Other (specify): _____
			iii. Where did you (or the ill person) stay while traveling domestically? (select all that apply): <input type="checkbox"/> Hotel, hostel, guest house, resort <input type="checkbox"/> Private home <input type="checkbox"/> Hospital <input type="checkbox"/> Cruise ship <input type="checkbox"/> Other (e.g., school, dormitory, tent) (specify): _____
			iv. What activities did you (or the ill person) engage in while traveling domestically? (select all that apply) <input type="checkbox"/> Purchase or eat food <input type="checkbox"/> Go swimming <input type="checkbox"/> Attend gathering of people <input type="checkbox"/> Drink untreated water <input type="checkbox"/> Other (specify): _____
			b. [If yes to question 1] List all countries outside the United States where you (or the ill person) traveled: _____ <input type="checkbox"/> Did not travel internationally
			i. List dates of international travel: _____
			ii. What was the purpose of this travel? (select all that apply) <input type="checkbox"/> Tourism <input type="checkbox"/> Work <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Other (specify): _____
			iii. Where did you (or the ill person) stay while traveling internationally? (select all that apply): <input type="checkbox"/> Hotel, hostel, guest house, resort <input type="checkbox"/> Private home <input type="checkbox"/> Hospital <input type="checkbox"/> Cruise ship <input type="checkbox"/> Other (e.g., school, dormitory, tent) (specify): _____
			iv. What activities did you (or the ill person) engage in while traveling internationally? (select all that apply) <input type="checkbox"/> Purchase or eat food <input type="checkbox"/> Go swimming <input type="checkbox"/> Attend gathering of people <input type="checkbox"/> Drink untreated water <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In the <u>past month</u> , have you (or the ill person) had contact with any individuals who traveled outside the United States?
			a. [If yes to question 2] Where did they travel? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Were they ill with symptoms similar to your (or the ill person's) symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Did you (or the ill person) eat any food or drink any beverages they brought back?
			i. What did you (or the ill person) eat or drink? (specify): _____
			3. In the 7 days before your (or the ill person's) illness started, did you (or the ill person) attend, visit, work in, or volunteer at any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. A religious gathering (such as church, mosque, or synagogue)? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Camp? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Conference or other large meeting? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Festival, fair, play, or concert? (specify): _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Party, picnic, or barbeque? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Sports practice, sports game, or exercise class? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Other gathering of people I did not ask about? (specify): _____
Yes	No	Don't Know	4. In the 7 days before your (or the ill person's) illness started, did you (or the ill person):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Drink water from an untreated source, such as lake, pond, or river? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Eat any foods prepared by a friend, neighbor, or coworker in their home? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Eat any foods prepared by a catering company? (such as food served at a wedding or conference?) (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Eat at a restaurant? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Swim in treated water, such as a swimming pool? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Swim in untreated water, such as a lake, river, or ocean? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Play in an interactive water fountain, water table, children's pool, kiddie pool, or baby pool? (specify): _____
			5. In the 7 days before your (or the ill person's) illness started, did you (or the ill person) visit, work in, or volunteer at:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. A place that serves food, such as a restaurant or cafeteria? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. A homeless shelter? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. A health care facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. A nursing home, long term care, or assisted living facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. In the 7 days before your (or the ill person's) illness started, did you (or the ill person) have contact with someone with diarrhea (at least 3 loose, watery stools in 24 hours) or symptoms similar to your (or the ill person's) symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. [If yes to question 6] Was this person diagnosed with a <i>Shigella</i> infection?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Was this person a member of your (or the ill person's) household? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Does this person wear diapers?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. [If yes to question 6e] Did you (or the ill person) change this person's diapers?
			7. While you (or the ill person) were sick with the <i>Shigella</i> infection, did you (or the ill person) do any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Prepare or handle food for other people? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Go swimming or play in a swimming pool, baby pool, interactive fountain, or water table? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Visit, work in, or volunteer at a healthcare facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Visit, work in, or volunteer at a nursing home, long term care, or assisted living facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Visit, work in, volunteer, or attend a school or childcare facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Visit, work in, volunteer, or attend any gathering of people? For example, a picnic, party, concert, conference, or religious gathering. (specify): _____

Section 7: CHILD CARE AND SCHOOL INFORMATION

Public reporting burden of this collection of information is estimated to average 45 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,

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the 7 days before your (or the ill person's) illness started, did you (or the ill person) visit, work in, volunteer, or attend a child care center, daycare, or preschool?
			a. [If yes to question 1] What is the name of the facility? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. At this facility were there any other children or adults ill with diarrhea (at least 3 loose, watery stools in 24 hours) or symptoms similar to yours (or the ill person's) before you (or the ill person) became ill?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Did you (or the ill person) use a school bus or other school transport to get to and from the child care center, daycare, or preschool?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Were you (or the ill person) excluded from this facility while ill?
			i. [If yes to question 1d] How many days were you (or the ill person) excluded? _____
			ii. [If yes to question 1d and case is ≤ 18 years] While excluded from daycare, what alternative care did your child receive? (select all that apply) <input type="checkbox"/> Babysitter <input type="checkbox"/> Care at home <input type="checkbox"/> Other childcare center <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In the 7 days before your (or the ill person's) illness started, did you (or the ill person) attend, visit, work in, or volunteer in a school (such as an elementary, middle, after school center, or other type of school)?
			a. [If yes to question 2] What is the name of the school? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. At this school were there any other children or adults ill with diarrhea (at least 3 loose, watery stools in 24 hours) or symptoms similar to your (or the ill person's) before you (or the ill person) became ill?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Did you (or the ill person) use a school bus or other school transport to get to and from the school?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Were you (or the ill person) excluded from school while ill?
			i. [If yes to question 2d] How many days were you (or the ill person) excluded? _____
			ii. [If yes to question 2d and case is ≤ 18 years] While excluded from school, what alternative care did your child receive? (select all that apply) <input type="checkbox"/> Babysitter <input type="checkbox"/> Care at home <input type="checkbox"/> Self-care <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____

[Proceed if participant is ≥ 18 years of age and answering survey on behalf of themself. Otherwise skip section 8 and conclude questionnaire]

Finally, we would like to ask about your recent sexual activity because *Shigella* can be spread through sexual contact. *Shigella* germs are very contagious; it takes just a small number of *Shigella* germs to make someone sick. People can get shigellosis when they put something in their mouths or swallow something that has come into contact with the stool of someone else who is sick with shigellosis. This can happen during sex.

As described previously, your responses are voluntary, and you may refuse to answer any question at any time. We ask all adults who were diagnosed with a *Shigella* infection these questions. Your answers to these questions will be kept private and may help us to identify how you became sick with a *Shigella* infection. This will also help us to prevent others from getting sick.

Do you wish to proceed with the next section?

If yes: [Begin section 8]

If no: [information about shigellosis please go to www.cdc.gov/shigella/]For more Thank you for your time. Go to the next page to end survey and submit your responses.

Section 8: RECENT SEXUAL ACTIVITY			
1. Which of the following best represents how you think of yourself? <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight, that is not lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else (specify): _____ <input type="checkbox"/> Unknown/I don't know <input type="checkbox"/> Prefer not to answer			
2. Do you currently describe yourself as male, female, or transgender? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> None of these <input type="checkbox"/> Prefer not to answer			
Yes	No	Prefer not to answer	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Are you currently sexually active? [If no skip to question 4]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. [If yes to question 3] Since your illness started, have you had sexual contact with another person? Sexual contact would include genital sex, anal sex, oral sex, or any other sexual contact.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. [If yes to question 3] In the 7 days before your illness started, did you have sexual contact with another person? Sexual contact would include genital sex, anal sex, oral sex, or any other sexual contact.
			i. [If yes to question 3b] Were your sex partners (select all that apply): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Another <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer Not to Answer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ii. In the 7 days before your illness started did any of your sex partners have diarrhea or symptoms similar to your own?
			[If yes to question 3b] The next questions will be more explicit about the kind of sex you had in the week before your illness started. This will help us to better understand how you could have become sick.
Yes	No	Prefer not to answer	iii. In the 7 days before your illness started, what kind of sexual contact did you have?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Genital sex (for example, penis in the vagina)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Anal sex (for example, penis in the anus)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Oral sex (for example, mouth on penis or vagina)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Anilingus or rimming (meaning mouth on anus)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Other sexual contact (for example touching your partner's anus with your hands, your partner touching your anus with their hands, or sharing of sex toys)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	iv. In the 7 days before your illness started did you use drugs or alcohol during or immediately before sex? Some examples include alcohol, Viagra, meth, GHB, cocaine, or poppers. (specify): _____
			v. In the 7 days before your illness, how many sex partners did you have? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. [If yes to question 3bv] Were any of these partners new?
			a. In the 7 days before your illness started, did you meet your new sex partner(s) at any of the following places?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Bar, restaurant or club? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ii. Bathhouse? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	iii. Bookstore? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	iv. Gym? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	v. Park? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vi. Social media sites? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vii. Dating or hookup sites? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	viii. Party, conference, or other type of event? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ix. Sex club or sex party? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	x. Other location I didn't ask about? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 12 months have you been told by a doctor that you have a sexually transmitted infection?
			a. [If yes to question 4] Which infection? (select all that apply)
			<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Genital warts <input type="checkbox"/> Herpes
			<input type="checkbox"/> Other (specify): _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2.

Section CLOSING: 9

Thank you for completing this survey.

Click the [button](#) to submit your responses! *Submit Survey*

CDC Team