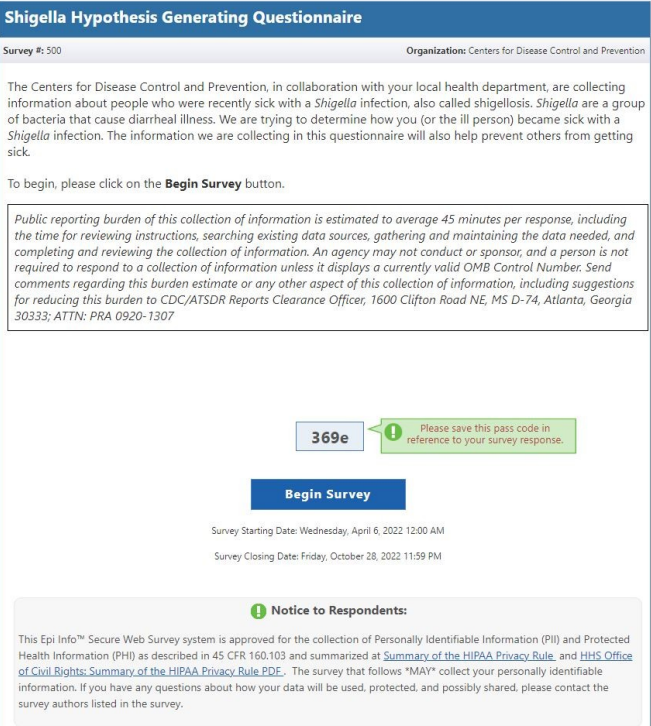


English SHGQ Side-by-Side Comparison by Modes of Administration

Description	Interviewer-administered form	Self-administered web form
<p>INTRODUCTION</p> <p>Allow respondent to provide information on behalf of their spouse or child</p>	<p><b>Hello, my name is &lt;interviewer name&gt;. I am from &lt;interviewer health department name&gt;. We are contacting you because you (or the ill person) were recently sick with a <i>Shigella</i> infection, also called shigellosis. <i>Shigella</i> are a group of bacteria that cause diarrheal illness. We are trying to determine how you (or the ill person) became sick with a <i>Shigella</i> infection. This interview will also help prevent others from getting sick.</b></p>	 <p><b>Shigella Hypothesis Generating Questionnaire</b></p> <p>Survey #: 500 Organization: Centers for Disease Control and Prevention</p> <p>The Centers for Disease Control and Prevention, in collaboration with your local health department, are collecting information about people who were recently sick with a <i>Shigella</i> infection, also called shigellosis. <i>Shigella</i> are a group of bacteria that cause diarrheal illness. We are trying to determine how you (or the ill person) became sick with a <i>Shigella</i> infection. The information we are collecting in this questionnaire will also help prevent others from getting sick.</p> <p>To begin, please click on the <b>Begin Survey</b> button.</p> <p><i>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, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-1307</i></p> <p><b>369e</b> Please save this pass code in reference to your survey response.</p> <p><b>Begin Survey</b></p> <p>Survey Starting Date: Wednesday, April 6, 2022 12:00 AM    Survey Closing Date: Friday, October 28, 2022 11:59 PM</p> <p><b>Notice to Respondents:</b></p> <p>This Epi Info™ Secure Web Survey system is approved for the collection of Personally Identifiable Information (PII) and Protected Health Information (PHI) as described in 45 CFR 160.103 and summarized at <a href="#">Summary of the HIPAA Privacy Rule</a> and <a href="#">HHS Office of Civil Rights: Summary of the HIPAA Privacy Rule PDF</a>. The survey that follows *MAY* collect your personally identifiable information. If you have any questions about how your data will be used, protected, and possibly shared, please contact the survey authors listed in the survey.</p>

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, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA 0920-1307.

CONSENT

Allow respondent to provide information on behalf of their spouse or child

**You may have already been contacted by the health department. I 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 interview will likely take about 25 to 30 minutes. Are you willing to participate?**

*If yes:* Thank you. [Proceed to Section 2]

*If no:* Thank you for your time. Would you like any additional materials about *Shigella* or can I answer any questions for you? If you wish at any time to complete the questionnaire, please call <health department phone number>.

The screenshot shows a web-based questionnaire interface. At the top, there is a blue header with the title 'Shigella Hypothesis Generating Questionnaire'. Below the header is a progress bar with 22 numbered steps. A navigation menu includes an 'Exit Survey' button. The main content area contains the consent text from the adjacent table. An 'ALERT' dialog box is displayed in the center, with the message: 'You have selected to participate in this survey. Move to the next page to begin the survey.' and an 'OK' button. Below the dialog, the consent text is partially visible, showing 'This questionnaire will likely t' and 'participate?' with radio buttons for 'YES' and 'NO'.

SECTION 1.  
INTERVIEW  
INFORMATI  
ON

**Section 1: INTERVIEW INFORMATION**

1. PulseNet ID #: _____	2. WGS ID #: _____
3. Interviewer information Name: _____ Agency or organization: _____	
4. Reporting state: _____	5. Reporting county: _____
6. Language interview conducted in: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify): _____	
7. Respondent was: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify): _____	

**Shigella Hypothesis Generating Questionnaire**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21  
22 23

Exit Survey

**SECTION 1: INTERVIEW INFORMATION**

1. Are you completing this interview on behalf of yourself or another person?

Self  Another Person

2. What best describes your relationship to the other person?

Spouse  Child  Other dependent  Other

i. (specify): \_\_\_\_\_

SECTION 2.  
CASE  
INFORMATI  
ON

Allow  
respondent  
to provide  
information  
on behalf of  
their  
spouse or  
child

**For the first few questions, I will ask some basic demographic questions so I can learn more about you (or the ill person).**

<b>Section 2: CASE INFORMATION</b>	
1. State (of residence): _____	2. County (of residence): _____
3. Age (of case): _____ <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	
How do you describe your (or the ill person's):	
6. Ethnicity? <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
7. Race? (select all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	
8. <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused	
8. If case is ≥14 years old, what is your (or the ill person's) current occupation? _____	

**Shigella Hypothesis Generating Questionnaire**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21  
22 23

Exit Survey

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 who is sick with shigellosis: 14  Years  Days  Months

4. What sex were you (or the ill person) assigned at birth?  
sex  
 Female  Male  Prefer not to answer

5. How do you describe your (or the ill person's) ethnicity:  
ethnicity  
 Hispanic or Latino  Not Hispanic or Latino

6. How do you describe your (or the ill person's) race:  
(select all that apply)  
 American Indian or Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian or Pacific Islander  
 White  
 Prefer not to answer

7. What is your (or the ill person's) current occupation?

SECTION 3.  
HOUSEHOL  
D  
INFORMATI  
ON

Allow  
respondent  
to provide  
information  
on behalf of  
their  
spouse or  
child

**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.  
 House/single family home    Apartment    Hotel/motel    Long term care facility    Nursing home/assisted living facility  
 Mobile home    Shelter    Rehabilitation center    Half-way house  
 Unknown    Other (specify): \_\_\_\_\_
2. In the past 30 days, 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?    Yes    No    Prefer not to answer    Unknown
3. In the past 30 days, were you (or the ill person) ever homeless? That is, were you (or the ill person) living on the street, in a shelter, in a single room occupancy hotel, or in a car?    Yes    No    Prefer not to answer    Unknown
4. What is the water source at your (or the ill person's) primary place of residence?  
 Municipal    Well    Unknown    Other (specify): \_\_\_\_\_
5. What is the sewer connection at your (or the ill person's) primary place of residence?  
 Municipal    Septic tank    Unknown    Other (specify): \_\_\_\_\_
6. How many people, including you (or the ill person), live in your (or the ill person's) primary place of residence? \_\_\_\_\_    Unknown
  - a. Do any of these people (either children or adults) wear diapers?    Yes    No    Unknown
  - b. How many people living in your (or the ill person's) household are under the age of 5? \_\_\_\_\_    Unknown
7. What was your (or the ill person's) household income last year from all sources before taxes? *That is, the total amount of money earned and shared by all people living in your (or the ill person's) household.*  
 <\$20,000    \$20,000-\$39,999    \$40,000-\$59,999    \$60,000-\$79,999    \$80,000-99,999    \$100,000 or more  
 Prefer not to answer    Unknown

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 checked="" type="checkbox"/> Other (specify): <input type="text"/> |                                                  |

2. In the past 30 days, 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?

3. In the past 30 days, 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?

4. What is the water source at your (or the ill person's) primary place of residence?

5. What is the sewer connection at your (or the ill person's) primary place of residence?

6. How many people, including you (or the ill person), live in your (or the ill person's) primary place of residence?

*click here if unknown number of people live in primary residence*

a. Do any of these people (either children or adults) wear diapers?

b. How many people living in your (or the ill person's) household are under the age of 5?

*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? *That is, the total amount of money earned and shared by all people living in your household.*

SECTION 4.  
CLINICAL  
INFORMATI  
ON

Allow  
respondent  
to provide  
information  
on behalf of  
their  
spouse or  
child

Next, I have a few questions about your (or the ill person's) recent illness. It may be helpful to have a calendar in front of you because I will be asking about the dates your (or the ill person's) symptoms started and stopped. Do you need some time to get one?

**Section 4: CLINICAL INFORMATION**

1. What date did you (or the ill person) first feel sick? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_   
Approximate date  Unknown   
Month / Day / Year

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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. If yes to question 3a, 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): _____

Shigella Hypothesis Generating Questionnaire

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21  
22 23

Exit Survey

SECTION 4: CLINICAL INFORMATION

1. What date did you (or the ill person) first feel sick? 08/01/2022  Approximate date  Unknown

2. What date did you (or the ill person) stop feeling sick? 08/03/2022  Approximate date  Unknown  
a. If unsure of specific dates in questions 1 and 2, about how many days were you (or the ill person) sick?  Ongoing

SYMPTOMS

3. Have you (or the ill person) had any of the following symptoms?

- a. Diarrhea (at least 3 loose, watery stools in 24 hours)
- i. About how many days did you (or the ill person) have diarrhea?
- b. Abdominal pain/cramps
- c. Fever
- d. Nausea
- e. Vomiting
- f. Bloody stools/bloody diarrhea
- g. Seizures
- h. Achy joints/muscles
- i. Tenesmus (or feeling the need to pass stool [poop] even when bowels are empty)
- j. Other symptoms

(specify):

SECTION 5. MEDICAL CARE AND TREATMENT INFORMATION

Allow respondent to provide information on behalf of their spouse or child

The next set of questions are about any recent medical care and treatment you (or the ill person) may have received.

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?
<p>a. If yes to question 1, where did you (or the ill person) seek medical care? (select all that apply)</p> <p><input type="checkbox"/> Doctor's office   <input type="checkbox"/> Urgent care   <input type="checkbox"/> Pharmacy clinic   <input type="checkbox"/> STD clinic</p> <p><input type="checkbox"/> Emergency department   <input type="checkbox"/> Hospital   <input type="checkbox"/> Unknown   <input type="checkbox"/> Other (specify): _____</p>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. If yes to question 1, were you (or the ill person) admitted to a hospital overnight?
<p>i. If yes to question 1b, for how many nights were you (or the ill person) hospitalized?</p> <p>_____</p>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. If yes to question 1, 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)?
<p>a. If yes to question 2, what was the name of the other infection(s): _____</p>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Were you (or the ill person) prescribed any antibiotics for this illness? If yes, I will be asking more questions about the antibiotic, so it may be helpful to get the pill bottles or packages if available.
<p>a. If yes to question 3, what was the name of the antibiotic(s), dose, and frequency?</p> <p>_____</p>			
<p>b. If yes to question 3, which date did you (or the ill person) start taking the antibiotic(s)?</p> <p>_____/_____/_____   <input type="checkbox"/> Approximate date   <input type="checkbox"/> Unknown</p> <p>Month / Day / Year</p>			
<p>c. If yes to question 3, which date did you (or the ill person) stop taking the antibiotic(s)?</p> <p>_____/_____/_____   <input type="checkbox"/> Approximate date   <input type="checkbox"/> Unknown   <input type="checkbox"/> Still taking antibiotic(s)</p>			

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**
- Get better/Improve    Stay the Same    Get Worse    Other (specify): \_\_\_\_\_

**SECTION 6. EXPOSURE INFORMATION**

Allow respondent to provide information on behalf of their spouse or child

**I would now like to know about your (or your child's) recent activities, including travel, events, and contact with others.**

<b>Section 6: EXPOSURE INFORMATION</b>		
<b>Yes</b>	<b>No</b>	<b>Don't Know</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>1. In the 7 days before your illness started, did you (or the ill person) spend any time outside of your home state?</b></p> <p><b>a. If yes to question 1, list all U.S. states where you (or the ill person) traveled:</b></p> <p>_____</p> <p><b>i. List dates of domestic travel:</b></p> <p>_____</p> <p><b>ii. What was the purpose of this travel? (select all that apply)</b></p> <p><input type="checkbox"/> Tourism   <input type="checkbox"/> Work   <input type="checkbox"/> Visiting friends/relatives</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><b>iii. Where did you (or the ill person) stay while traveling domestically? (select all that apply):</b></p> <p><input type="checkbox"/> Hotel, hostel, guest house, resort   <input type="checkbox"/> Private home   <input type="checkbox"/> Hospital   <input type="checkbox"/> Cruise ship</p> <p><input type="checkbox"/> Other (e.g., school, dormitory, tent) (specify): _____</p> <p><b>iv. What activities did you (or the ill person) engage in while traveling domestically? (select all that apply)</b></p> <p><input type="checkbox"/> Purchase or eat food   <input type="checkbox"/> Go swimming   <input type="checkbox"/> Attend gathering of people</p> <p><input type="checkbox"/> Drink untreated water   <input type="checkbox"/> Other (specify): _____</p> <p><b>b. If yes to question 1, list all countries outside the</b></p>		

**SECTION 6: EXPOSURE INFORMATION**

1. In the 7 days before your illness started, did you (or the ill person) spend any time outside of your home state?

Yes    No    Don't Know

**DOMESTIC TRAVEL**

a. List all U.S. states where you (or the ill person) traveled: \_\_\_\_\_

Did not travel domestically

i. List dates of domestic travel: \_\_\_\_\_

ii. What was the purpose of this travel? (select all that apply)

Tourism    Work    Visiting friends/relatives

Other (specify): \_\_\_\_\_

iii. Where did you (or the ill person) stay while traveling domestically? (select all that apply)

Hotel, hostel, guest house, resort

Private home    Hospital    Cruise ship

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)

Purchase or eat food    Go swimming    Attend gathering of people

Drink untreated water    Other (specify): \_\_\_\_\_



			United States where you (or the ill person) traveled: _____ <input type="checkbox"/> Did not travel internationally
			<b>i.</b> List dates of international travel: _____ _____
			<b>ii.</b> What was the purpose of this travel? ( <i>select all that apply</i> ) <input type="checkbox"/> Tourism <input type="checkbox"/> Work <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Other (specify): _____
			<b>iii.</b> Where did you (or the ill person) stay while traveling internationally? ( <i>select all that apply</i> ): <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): _____
			<b>iv.</b> What activities did you (or the ill person) engage in while traveling internationally? ( <i>select all that apply</i> ) <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"/>	<b>2.</b> In the <u>past month</u> , have you (or the ill person) had contact with any individuals who traveled outside the United States?
			<b>a.</b> <b>If yes to question 2</b> , where did they travel? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</b> <b>If yes to question 2</b> , were they ill with symptoms similar to your (or the ill person's) symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>c.</b> <b>If yes to question 2</b> , did you (or the ill person) eat any food or drink any beverages they brought back?
			<b>i.</b> <b>If yes to question 2c</b> , what did you (or the ill person) eat or drink? (specify): _____
			<b>3.</b> In the <u>7 days before</u> 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"/>	<b>a.</b> A religious gathering (such as church, mosque, or synagogue)? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</b> Camp? (specify): _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>c.</b> Conference or other large meeting? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>d.</b> Festival, fair, play, or concert? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>e.</b> Party, picnic, or barbeque? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>f.</b> Sports practice, sports game, or exercise class? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>g.</b> Other gathering of people I did not ask about? (specify): _____
<b>Y e s</b>	<b>N o</b>	<b>D o ' t K n o w</b>	<b>4.</b> In the <u>7 days before</u> your (or the ill person's) illness started, did you (or the ill person):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>a.</b> Drink water from an untreated source, such as lake, pond, or river? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</b> Eat any foods prepared by a friend, neighbor, or coworker in their home? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>c.</b> 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"/>	<b>d.</b> Eat at a restaurant? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>e.</b> Swim in treated water, such as a swimming pool? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>f.</b> Swim in untreated water, such as a lake, river, or ocean? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>g.</b> Play in an interactive water fountain, water table, children's pool, kiddie pool, or baby pool? (specify): _____
			<b>5.</b> In the <u>7 days before</u> 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"/>	<b>a.</b> A place that serves food, such as a restaurant or cafeteria? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</b> A homeless shelter? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>c.</b> A health care facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>d.</b> A nursing home, long term care, or assisted living facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>6.</b> In the <u>7 days before</u> 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"/>	<b>a. If yes to question 6,</b> was this person diagnosed with a <i>Shigella</i> infection?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b. If yes to question 6,</b> was this person a member of your (or your child's) household? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>c. If yes to question 6,</b> does this person wear diapers?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>i. If yes to question 6e,</b> did you (or your child) change this person's diapers?
			<b>7. While you (or the ill person) were sick</b> 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"/>	<b>a.</b> Prepare or handle food for other people? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</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"/>	<b>c.</b> Visit, work in, or volunteer at a healthcare facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>d.</b> 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"/>	<b>e.</b> Visit, work in, volunteer, or attend a school or childcare facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>f.</b> 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  
INFORMATI  
ON

Allow  
respondent  
to provide  
information  
on behalf of  
their  
spouse or  
child

**We are nearly finished. I have a few questions about your (or your child's) recent child care or school attendance.**

<b>Section 7: CHILD CARE AND SCHOOL INFORMATION</b>			
<b>Ye s</b>	<b>N o</b>	<b>Don' t Kno w</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>1.</b> In the <u>7 days before</u> 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?
			<b>a.</b> If <b>yes to question 1</b> , what is the name of the facility? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</b> If <b>yes to question 1</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"/>	<b>c.</b> If <b>yes to question 1</b> , 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"/>	<b>d.</b> If <b>yes to question 1</b> , were you (or the ill person) excluded from this facility while ill?
			<b>i.</b> If <b>yes to question 1d</b> , how many days were you (or the ill person) excluded? _____
			<b>ii.</b> If <b>yes to question 1d and case is ≤ 18 years</b> , while excluded from daycare, what alternative care did your child receive? ( <i>select all that apply</i> ) <input type="checkbox"/> Babysitter <input type="checkbox"/> Care at home <input type="checkbox"/> Other child care center <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>2.</b> In the <u>7 days before</u> 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)?
			<b>a.</b> If <b>yes to question 2</b> , what is the name of the school? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>b.</b> If <b>yes to question 2</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

**SECTION 7: CHILD CARE AND SCHOOL**

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?

Yes    No    Don't Know

a. What is the name of the facility? \_\_\_\_\_

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?

Yes    No    Don't Know

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?

Yes    No    Don't Know

d. Were you (or the ill person) excluded from the facility while ill?

Yes    No    Don't Know

i. How many days were you (or the ill person) excluded? \_\_\_\_\_

ii. If case is under 18 years old, while excluded from daycare, what alternative care did your child receive? (select all that apply)

Babysitter  
 Care at home  
 Other child care center  
 Unknown  
 Other (specify): \_\_\_\_\_

			similar to your (or the ill person's) before you became ill?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>c. If yes to question 2</b> , 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"/>	<b>d. If yes to question 2</b> , were you (or the ill person) excluded from school while ill?	
			<b>i. If yes to question 2d</b> , how many days were you (or the ill person) excluded? _____	
			<b>ii. If yes to question 2d and case is ≤ 18 years</b> , while excluded from school, what alternative care did your child receive? ( <i>select all that apply</i> ) <input type="checkbox"/> Babysitter <input type="checkbox"/> Care at home <input type="checkbox"/> Self-care <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____	

CONSENT:  
RECENT  
SEXUAL  
ACTIVITY  
SECTION

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

**Finally, I 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 I stated 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:** Thank you [Begin section 8]

**If no:** That is OK. We appreciate the information you have given us.  Refused/Prefer Not to Complete  
[Skip to Section 9 to close out interview]

### Shigella Hypothesis Generating Questionnaire

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21  
22 23

#### SEXUAL ACTIVITY SECTION

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.

#### CONSENT

Do you wish to proceed with the next section?

YES  NO

SECTION 8.  
RECENT  
SEXUAL  
ACTIVITY  
(Only ask if  
≥ 18 years  
of age)

The answer choice of “Don’t know” for these questions was replaced with “Prefer not to answer” to more appropriately reflect answering sensitive questions

**Section 8: RECENT SEXUAL ACTIVITY [Only ask if ≥ 18 years of age]**

1. Which of the following best represents how you think of yourself?  
 Lesbian or gay  Straight, that is not lesbian or gay  Bisexual  Something else (specify): \_\_\_\_\_  
 I don't know  Prefer not to answer
2. Do you currently describe yourself as male, female, or transgender?  
 Male  Female  Transgender  None of these  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
			Answer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ii. If yes to question 3b, in the 7 days before your illness started did any of your sex partners have diarrhea or symptoms similar to your own?
			<b>If yes to question 3b, read prompt.</b> For the next questions I'm going to be more explicit about the kind of sex you had in the week before your illness started. This will help me to better understand how you could have become sick.
			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)?

SECTION 8: RECENT SEXUAL ACTIVITY

1. Which of the following best represents how you think of yourself?

2. Do you currently describe yourself as male, female, or transgender?

3. Are you currently sexually active?

a. 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.  
 Yes  No  Prefer not to answer

b. 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.  
 Yes  No  Prefer not to answer

i. Were your sex partners (select all that apply):  
 Female  
 Male  
 Transgender Female  
 Transgender Male  
 Another  
 Unknown  
 Prefer not to answer

ii. In the 7 days before your illness started did any of your sex partners have diarrhea or symptoms similar to your own?  
 Yes  No  Don't Know

<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. If yes to question 3b, in the <u>7 days before</u> 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 <u>7 days before</u> 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. If yes to question 3bv1, in the <u>7 days before</u> 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"/>	<p>4. In the <u>past 12 months</u> have you been told by a doctor that you have a sexually transmitted infection?</p> <p>a. <b>If yes to question 4</b>, which infection? <i>(select all that apply)</i></p> <p><input type="checkbox"/> Chlamydia   <input type="checkbox"/> Gonorrhea   <input type="checkbox"/> Syphilis   <input type="checkbox"/> Genital warts   <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Other (specify): _____</p>	
SECTION 9. CLOSING	<p><b>Section 9: <u>CLOSING</u></b></p> <p>This is the end of the questionnaire. Thank you very much for your time. Would you like any additional materials about <i>Shigella</i> or can I answer any questions for you?</p> <p><b>Thank you for your time. Have a nice day.</b></p> <p><i>[Conclude interview]</i></p>			<p><b>SURVEY COMPLETED</b></p> <p><b>Thank you for completing this survey.</b></p> <p>Click the <i>Submit Survey</i> button to submit your responses!</p> <p>CDC Team</p>	