**Submission Instructions:**

CDC requests submission of completed forms on a rolling basis. Please upload completed forms to the ShareFile folder via one of the following:

1. Scanned/electronic copy of the completed form
2. CSV export from REDCap database (if using CDC REDCap data structure in state/local REDCap instance)

For questions related to form completion or submission instructions, email [ncirddvdgast@cdc.gov](mailto:ncirddvdgast@cdc.gov).

**Suggested script:**

Thank you so much for agreeing to speak with us. Again, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I am working with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We are collaborating with the CDC on an investigation of children with hepatitis (severe liver inflammation). It is our hope that by talking with parents like you, we can learn more about what might be causing this illness and help keep people safe. During this conversation, which might take about 45 minutes, I will be asking for more detail about your child’s illness, their general health status, and their activities and diet leading up to their illness. I will also ask about the other people living in your home and whether they had any illnesses around the time that your child became sick. Am I speaking with the right person to provide this kind of information? *(If no, ask who would be a better source, and get their name and contact information.)* Thank you.

Please stop me at any time during the interview if a question is unclear. I would like to begin by asking some general information about your child and household.

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| INTERVIEW INFORMATION | |
| Date of interview (mm/dd/yyyy) :  \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_  Time of interview: \_\_\_\_\_\_:\_\_\_\_\_\_AM/PM | Interviewer Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Interviewer Institution : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Interviewer Email : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Language of interview: | ☐ English ☐ Spanish ☐ Other, specify: |
| Interpretor used? | ☐ Yes ☐ No |
| Relationship of respondent to the case (if not interviewing the case): | |

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| PATIENT DEMOGRAPHICS | | |
| First Name: | Middle Name: | Last Name: |
| Date of birth (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | | |
| What sex was your child assigned at birth? ☐ Male ☐ Female ☐ Refused ☐ Don’t know | | |
| Is your child of Hispanic, Latino/a, or Spanish origin? | ☐ Hispanic or Latino ☐ Non-Hispanic or Latino *(skip to race)* ☐ Unknown | |
| If yes, which country or countries of origin/ancestry? |  | |
| Which of the following describe your child’s race? *Check all that apply* | ☐ American Indian / Alaska Native ☐ Native Hawaiian / Other Pacific Islander  ☐ Asian ☐ White  ☐ Black / African American ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Address: | City: | State: |
| County: | ZIP: | Phone: |

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| HOUSEHOLD STRUCTURE | | | |
| Including the patient, how many people live in your household?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list out ALL of the members of your household  *Interviewer, please ensure that the parent includes* ***both themself and the patient*** *in the overall count and below table* | | | |
|  | *Relationship to child* | *Age (yrs)* | *Occupation (adults)\* or name of school/daycare attended (children)\*\** |
| **A** |  |  |  |
| **B** |  |  |  |
| **C** |  |  |  |
| **D** |  |  |  |
| **E** |  |  |  |
| **F** |  |  |  |
| **G** |  |  |  |
| **H** |  |  |  |

\*Probe for informal work arrangements such as in-home daycare. \*\*Occupation should be reported to CDC but daycare name is not required.

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| Please list out anybody else who cares for your child on a daily or weekly basis (e.g., grandparent, other relative, nanny).  ☐ No one else ☐ Unknown | | | |
|  | *Relationship to child* | *Age (yrs)* | *Occupation (adults) or school/daycare attended (children)* |
| **A** |  |  |  |
| **B** |  |  |  |
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| PATIENT GENERAL HEALTH INFORMATION | | |
| I’d like to ask some general questions about your child’s health status prior to this illness. | | |
| Does your child have any known food allergies? ☐ Yes ☐ No ☐ Unk | | If yes, specify: |
| Has your child ever been diagnosed with any of the following chronic medical conditions? ☐ Yes ☐ No ☐ Unk  *If yes, check all that apply* | | |
| □ Asthma or Reactive Airway Disease  □ Congenital Heart Defect  □ Diabetes Mellitus (Type 1 or 2)  □ Leukemia/Lymphoma  □ Immunosuppressive Therapy (steroids, chemotherapy, etc.)  *Specify :* | □ Other cancer, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other developmental disorder, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Premature Birth (Gestational age at birth: \_\_\_\_\_\_ wks)  □ Seizure / seizure disorder  □ Sickle cell anemia  □ Other condition, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Does your child regularly take any prescription medications? | ☐ Yes ☐ No ☐ Unknown | |
| What medication(s): | | |

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| ELICITATION OF SPECIFIC MEDICATIONS | | | | | |
| In the 2 months prior to the onset of your child’s illness, did they receive any of the following treatments or medicines?  ☐ Yes ☐ No ☐ Unknown ***If yes***, specify below.  *If child never took product during time frame, mark “Never” in frequency. Otherwise indicate how often (e.g., daily (1x/day), weekly (1x/week), monthly (1x/month), as needed)* | | | | | |
| *Medication / Drug* | *First date given (mm/yyyy)* | *Frequency* | *Length of use (days)* | *Brand/Product* | *Reason* |
| Acetaminophen (like Tylenol) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Allergy medicine (like Zyrtec, Claritin, Benadryl) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Aspirin (like Bayer) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Cough syrup (like Robitussin) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Ibuprofen (like Advil or Motrin) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Simethicone drops (like Mylicon) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Any other over-the-counter drugs |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Herbal medicine or supplement |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Naturopathic or homeopathic medicine (e.g., pulsatilla, belladonna) |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
| Vitamins |  | ☐ As needed ☐ Daily  ☐ Weekly ☐ Monthly  ☐ Never ☐ Unknown |  |  |  |
|  | | | | | |
| Is there any possibility that a friend or family member could have given the child any medication/herbal/supplement not included above during any time in the 2 months prior to your child’s illness? ☐ Yes ☐ No | | | | | |

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| PATIENT HISTORY OF PREVIOUS ILLNESSES | | | | | | |
| Has your child ever had COVID-19? ☐ Yes, confirmed ☐ Yes, but not confirmed w/ a test ☐ No ☐ Unknown  *Please list all known or suspected COVID-19 infections for your child.* | | | | | | |
| *Confirmed with a test? (Yes – PCR, Yes – rapid antigen, Yes – Unk type, No)* | *Date onset (mm/dd/yyyy)* | | *Highest level of care (home, PCP, etc.)* | *Symptom status (symptomatic / asx)* | | *Any medications or treatments given* |
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| Please describe any other illnesses your child experienced in the 2 months prior to their illness which required treatment or care.  ☐ No illnesses ☐ Unknown | | | | | | |
| *Illness type (e.g., influenza, stomach bug) and clinical diagnosis if available* | *Date onset (mm/dd/yyyy)* | *Highest level of care (none, PCP, ED, hospital)* | | | *Any medications or treatments given* | |
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| Please describe any more-serious-than-usual injuries (requiring stitches or a trip to the doctor) where the skin was broken in the 2 months prior to your child’s illness. ☐ No injuries ☐ Unknown | | | | | | |
| *Location on body* | *Date (mm/dd/yyyy)* | | *Item causing injury* | | *Treatment & any unusual reaction* | |
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| Did your child get any piercings in the 2 months before their illness began? ☐ Yes ☐ No ☐ Unknown | | | | | | |
| *Location on body* | *Date (mm/dd/yyyy)* | | *Facility name* | | | |
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| PATIENT HISTORY OF HEPATITIS ILLNESS | | | | | |
| Approximately when did your child’s symptoms begin? (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | | | | | |
| During your child’s illness, did he or she have any of the following symptoms? *Please check all that apply* | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | a. | Felt feverish or hot | ☐ Yes ☐ No ☐ Unknown | h. | Diarrhea | ☐ Yes ☐ No ☐ Unknown | | b. | Temperature ≥ 100 °F OR 37.8 °C | ☐ Yes ☐ No ☐ Unknown | i. | Nausea | ☐ Yes ☐ No ☐ Unknown | | c. | Abdominal pain | ☐ Yes ☐ No ☐ Unknown | j. | Pale stool | ☐ Yes ☐ No ☐ Unknown | | d. | Conjunctivitis (pink eye / red, irritated eyes) | ☐ Yes ☐ No ☐ Unknown | k. | Sore throat | ☐ Yes ☐ No ☐ Unknown | | e. | Cough / runny nose | ☐ Yes ☐ No ☐ Unknown | l. | Tiredness/fatigue | ☐ Yes ☐ No ☐ Unknown | | f. | Dark-colored urine | ☐ Yes ☐ No ☐ Unknown | m. | Yellow skin / eyes | ☐ Yes ☐ No ☐ Unknown | | g. | Decreased appetite | ☐ Yes ☐ No ☐ Unknown | n. | Vomiting | ☐ Yes ☐ No ☐ Unknown | | o. | Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ Yes ☐ No ☐ Unknown |  |  | | | | | | | |
| Which was the first symptom to appear? | | | | | |
| Did you give your child any over-the-counter medications or home treatments for this illness? ☐ Yes ☐ No ☐ Unknown | | | | | |
| If yes, what? *Prompt to include herbal/other remedies.* | | | | | |
| Where did you seek care for your child’s illness? *(Prompt and mark all that apply below)* | | | | | |
| Primary care provider? | | * Yes ☐ No ☐ Unk | | Date (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | |
| Urgent care? | | * Yes ☐ No ☐ Unk | | Date (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | |
| Emergency department? | | * Yes ☐ No ☐ Unk | | Date (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | |
| Other? (specify:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Yes ☐ No ☐ Unk | | Date (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | |
| Was your child prescribed any medications during these visits? | | | | * Yes ☐ No ☐ Unknown | |
| If yes, what was prescribed? | * Antibiotics (specify name): * Other (specify): | | | | |
| Was your child admitted to the hospital because of this illness? | | | | | * Yes ☐ No |
| If yes, what was the name of the hospital? | | |  | | |
| What was the date of admission? | | | Date (mm/dd/yyyy): \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_ | | |

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| PATIENT EXPOSURES: SCHOOL / DAYCARE / EXTRACURRICULARS | | | | | |
| Did your child attend in-person school or daycare (including informal daycare arrangement) in the month before they became sick with hepatitis? ☐ Yes ☐ No | | | If yes, Grade / classroom: | | |
| Name of school/daycare: | | | Days per week: | | Hours/day: |
| When did your child first start attending daycare or school (including pre-COVID)? Mm/yyyy \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ ☐ N/A | | | | | |
| Approximately how many months in 2020 did your child attend school or daycare **in-person**?*If none, mark 0.* | | | | | |
| Approximately how many months in 2021 did your child attend school or daycare **in-person**? *If none, mark 0.* | | | | | |
| Approximately how many months in the past 12 months did your child attend school or daycare **in-person**? *If none, mark 0.* | | | | | |
| Were any outbreaks reported by school / daycare in the 2 months prior to onset of your child’s illness ? ☐ Yes ☐ No ☐ Unk | | | | | |
| If yes, what was the outbreak cause? | | When? (mm/yyyy) (list 3 most recent in order) | | Any notes from parent | |
| **A** |  | \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ | |  | |
| **B** |  | \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ | |  | |
| **C** |  | \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_ | |  | |
| Does your child participate in any athletic activities (e.g., soccer, swimming)? ☐ Yes ☐ No ☐ Unk | | | | | |
| If yes, which activities and how often? | | | | | |
| Does your child participate in any non-athletic group activities (e.g., group music class, language school)? ☐ Yes ☐ No ☐ Unk | | | | | |
| If yes, which activities and how often? | | | | | |

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| PATIENT EXPOSURES: ILLNESS IN CLOSE CONTACTS | | | |
| Please provide details for any new illnesses or infections in household members or other close contacts in the 2 months prior to the onset of your child’s illness. Close contacts might include grandparents, teachers, or playgroup members. If multiple persons, include as group.  ☐ No ill contacts ☐ Unk | | | |
| *Relationship to child* | *Illness type (e.g., COVID, stomach bug)* | *Approximate date of onset (mm/dd/yyyy)* | *Do you think this was linked to your child’s illness?* |
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| PATIENT EXPOSURES: TRAVEL | | | | |
| In the 2 months before their illness, did your child take any trips where they spent at least one night away from home (including within and outside the US)? ☐ Yes ☐ No ☐ Unk | | | | |
| *Dates (mm/dd/yyyy)* | *Destination* | *Length (days)* | *Anything unusual? (illness, insect, animal, activity)* | |
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| In the 2 months before your child’s illness, did any other household member travel away from home (any destination)?  ☐ Yes ☐ No ☐ Unk | | | | |
| *Relationship to case* | *Destination* | *Dates* | *Length* | *Anything unusual? (see above)* |
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| PATIENT EXPOSURES: ANIMALS AND INSECTS | | | |
| Did you have any pets or other animals living on your property at the time of your child’s illness?  ☐ Yes ☐ No ☐Unk **If yes**, please list*.* | | | |
| *Type of animal* | *Animal lives in the house?* | *Animal sleeps with child?* | *Any animal illnesses in that timeframe? Date / type* |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |

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| In the 2 months before their illness began, did your child have any contact with animals at friends’ or relatives’ homes?  ☐ Yes ☐ No ☐ Unk | | | |
| *Type of animal* | *Animal lives in the house?* | *Animal sleeps with child?* | *Any animal illnesses in that timeframe? Date / type* |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
|  | ☐ Yes ☐ No ☐ Unk | ☐ Yes ☐ No ☐ Unk |  |
| In the 2 months before their illness, did your child have any contact with other domestic animals (e.g., petting zoo)? ☐ Yes ☐ No ☐ Unk | | | |
| If yes, describe date (month/year) and location: | | | |
| In the 2 months before their illness began, did your child have any contact with wild animals (deer, birds, squirrels, snakes, etc.)? This could include bites as well as any interaction with animal feces. ☐ Yes ☐ No ☐ Unk | | | |
| If yes, describe animal, date, encounter: | | | |
| In the 2 months before their illness, did your child have any unusual bug bites, with any reaction? This could include an unusual number of bites at once (e.g., mosquito) or a bug that your child doesn’t usually encounter (like a tick, spider, or flea) or that could not be identified, or a reaction that is unusual for your child. ☐ Yes ☐ No ☐ Unk | | | |
| If yes, describe date, bug if known, reaction: | | | |

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| PATIENT EXPOSURES: WATER |
| What is the water supply to the home? ☐ Municipal (piped) ☐ Well ☐ Hauled water ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What is the sewage system? ☐ Municipal sewer ☐ Septic tank ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Were there any water or sewer problems in the 2 months prior to your child’s illness? ☐ Yes ☐ No ☐ Unk  If yes, what: |
| In the 2 months prior to their illness, did your child swim or play in any natural bodies of water (creek / river, ocean, lake, etc.)?  ☐ Yes ☐ No ☐ Unk If yes, which body of water and date: |

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| PATIENT EXPOSURES: FOOD | |
| Does your child follow any special diets or eat certain types of food? ☐ Yes ☐ No  If yes, specify (e.g., vegetarian, Halal, organic, dairy-free, gluten-free, etc.): | |
| Thinking back to your child’s diet around the time of their illness, can you please note how frequently they ate the following food types? | |
| *Food item* | *Frequency of consumption (at least once per day, per week, per month, less often, or never)* |
| Infant formula, if yes, brand: | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Baby food “pouches” (e.g., fruit, veggie, oatmeal, yogurt),  *if yes, brand(s):* | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Other “toddler” foods (e.g., “puffs”) | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Honey | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Soft cheeses (e.g., queso fresco, feta, blue cheese) | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Yogurt, milk, or other dairy products | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Unpasteurized (“raw”) milk or other dairy product | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Uncooked/raw vegetables | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Fresh or frozen berries | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Fresh herbs or sprouts | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Mushrooms or mushroom powder | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Fish or shellfish | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Meat or poultry | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Herbal teas | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Bottled water *Probe for “Real Water” brand bottled alkaline water* | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Foods brought from another country, if yes, specify: | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |
| Other food item of note not mentioned above. If yes, specify: | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐ Unk |

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| Did your child have any notable changes to their diet in the month before their illness began? (E.g., started eating new foods, switched brand of staple item) ☐ Yes ☐ No ☐ Unknown  If yes, please specify: |
| Did your child eat any new or unusual foods in the month before their illness began, including any seasonal chocolate (*ask specifically about Kinder chocolate products*), food foraged from the wild (berries, mushrooms), herbal teas or powders, or unpasteurised dairy?  ☐ Yes ☐ No ☐ Unknown If yes, describe & date: |
| In the month before their illness began, did your child eat any food that was moldy/rancid (sources may include nuts, corn, rice, flour, grains, breads, cheeses)? ☐ Yes ☐ No ☐ Unknown  If yes, describe & date: |

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| --- |
| PATIENT EXPOSURES: OTHER ENVIRONMENTAL EXPOSURES |
| Did your child or anyone in your household start using any new personal care products (e.g., soaps, lotions) in the 2 months before your child’s illness began? ☐ Yes ☐ No ☐ Unsure If yes, specify: |
| Did your child ever eat alcohol-based hand sanitizer before their illness?  ☐ Yes ☐ No ☐ Unknown If yes, specify date and what happened: |

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| PATIENT EXPOSURES: OTHER |
| What do you think caused your child’s hepatitis? Are there any other remarkable events, interactions, or experiences in the few months before your child’s illness that haven’t been discussed so far that might be important? This may include parties, functions, daytrips, or any new types of toys (like playdough or other molding clay). If yes, please describe: |

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| SOCIOECONOMIC STATUS | |
| What type of health care insurance does the child currently have? (check all that apply) | ☐ Private (e.g. HMO, PPO, managed care plan)             ☐ Uninsured  ☐ Medicaid/state assistance program  ☐ Unknown  ☐ Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What is the highest grade or year of school completed by the child’s parent/guardian? | ☐ No high school ☐ Some college  ☐ Some high school ☐ College graduate  ☐ High school graduate/GED ☐ Postgraduate/professional  ☐ Technical school ☐ Unknown/refused |
| In your [*participant’s name*] home, what is the annual household income before taxes for the last calendar year from all sources, including social security and pensions? [read options] | ☐ Less than $25,000 ☐ $75,000 or more  ☐ Between $25,000 to <$50,000 ☐ Unknown/refused  ☐ Between $50,000 to <$75,000 |