

**Attachment B. Pediatric Hepatitis of Unknown Etiology - Exposures Questionnaire  
(Parental Interview)**

Form Approved  
OMB No. 0920-0879  
Exp. Date 08/31/2026

CASE ID: \_\_\_\_\_

Version 16 June 2022

**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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CDC estimates the average public reporting burden for this collection of information as 45 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0879).

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INTERVIEW INFORMATION	
Date of interview (mm/dd/yyyy) : ____ / ____ / _____	Interviewer Name : _____ Interviewer Institution : _____ Interviewer Email : _____
Time of interview: ____:____ AM/PM	
Language of interview:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, specify:
Interpreter used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship of respondent to the case (if not interviewing the case):	

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

HOUSEHOLD STRUCTURE			
Including the patient, how many people live in your household? _____ Please list out ALL of the members of your household <i>Interviewer, please ensure that the parent includes both themselves and the patient in the overall count and below table</i>			
	Relationship to child	Age (yrs)	Occupation (adults)* or name of school/daycare attended (children)**
A			
B			

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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.

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			
C			
D			
E			
F			

## 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*

<input type="checkbox"/> Asthma or Reactive Airway Disease <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> Diabetes Mellitus (Type 1 or 2) <input type="checkbox"/> Leukemia/Lymphoma <input type="checkbox"/> Immunosuppressive Therapy (steroids, chemotherapy, etc.) Specify :	<input type="checkbox"/> Other cancer, specify: _____ <input type="checkbox"/> Other developmental disorder, specify: _____ <input type="checkbox"/> Premature Birth (Gestational age at birth: _____ wks) <input type="checkbox"/> Seizure / seizure disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Other condition, specify _____
--	---

Does your child regularly take any prescription medications?     Yes     No     Unknown

What medication(s):

## 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

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Acetaminophen (like Tylenol)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Allergy medicine (like Zyrtec, Claritin, Benadryl)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Aspirin (like Bayer)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Cough syrup (like Robitussin)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Ibuprofen (like Advil or Motrin)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Simethicone drops (like Mylicon)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Any other over-the-counter drugs	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Herbal medicine or supplement	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Naturopathic or homeopathic medicine (e.g., pulsatilla, belladonna)	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Unknown			
Vitamins	<input type="checkbox"/> As needed <input type="checkbox"/> Weekly <input type="checkbox"/> Never	<input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> 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

**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

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)

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			Any medications or treatments given

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

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

**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                            | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | h. Diarrhea           | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| b. Temperature ≥ 100 °F OR 37.8 °C                 | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | i. Nausea             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| c. Abdominal pain                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | j. Pale stool         | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| d. Conjunctivitis (pink eye / red, irritated eyes) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | k. Sore throat        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| e. Cough / runny nose                              | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | l. Tiredness/fatigue  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| f. Dark-colored urine                              | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | m. Yellow skin / eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| g. Decreased appetite                              | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | n. Vomiting           | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| o. Other (specify): _____                          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.*

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Where did you seek care for your child's illness? (Prompt and mark all that apply below)		
Primary care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date (mm/dd/yyyy): ____ / ____ / _____
Urgent care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date (mm/dd/yyyy): ____ / ____ / _____
Emergency department?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date (mm/dd/yyyy): ____ / ____ / _____
Other? (specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date (mm/dd/yyyy): ____ / ____ / _____
Was your child prescribed any medications during these visits?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, what was prescribed?	<input type="checkbox"/> Antibiotics (specify name): <input type="checkbox"/> Other (specify):	
Was your child admitted to the hospital because of this illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what was the name of the hospital?		
What was the date of admission?	Date (mm/dd/yyyy): ____ / ____ / _____	

### 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ____ / ____ ____ <input type="checkbox"/> N/A		
Approximately how many months in 2020 did your child attend school or daycare <b>in-person</b> ? If none, mark 0.		
Approximately how many months in 2021 did your child attend school or daycare <b>in-person</b> ? If none, mark 0.		
Approximately how many months in the past 12 months did your child attend school or daycare <b>in-person</b> ? If none, mark 0.		
Were any outbreaks reported by school / daycare in the 2 months prior to onset of your child's illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
If yes, what was the outbreak cause?	When? (mm/yyyy) (list 3 most recent in order)	Any notes from parent
<b>A</b>	____ / _____	
<b>B</b>	____ / _____	
<b>C</b>	____ / _____	
Does your child participate in any athletic activities (e.g., soccer, swimming)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
If yes, which activities and how often?		

### 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. <input type="checkbox"/> No ill contacts <input type="checkbox"/> Unk			
Relationship to child	Illness type (e.g., COVID, stomach bug)	Approximate date of	Do you think this was linked

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		<i>onset (mm/dd/yyyy)</i>	<i>to your child's illness?</i>

**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

<i>Dates (mm/dd/yyyy)</i>	<i>Destination</i>	<i>Length (days)</i>	<i>Anything unusual? (illness, insect, animal, activity)</i>

In the 2 months before your child's illness, did any other household member travel away from home (any destination)?  
 Yes  No  Unk

<i>Relationship to case</i>	<i>Destination</i>	<i>Dates</i>	<i>Length</i>	<i>Anything unusual? (see above)</i>

**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.**

<i>Type of animal</i>	<i>Animal lives in the house?</i>	<i>Animal sleeps with child?</i>	<i>Any animal illnesses in that timeframe? Date / type</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
--	---	---	--

In the 2 months before their illness began, did your child have any contact with animals at friends' or relatives' homes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
<i>Type of animal</i>	<i>Animal lives in the house?</i>	<i>Animal sleeps with child?</i>	<i>Any animal illnesses in that timeframe? Date / type</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
In the 2 months before their illness, did your child have any contact with other domestic animals (e.g., petting zoo)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
If yes, describe date, bug if known, reaction:			

<b>PATIENT EXPOSURES: WATER</b>			
What is the water supply to the home? <input type="checkbox"/> Municipal (piped) <input type="checkbox"/> Well <input type="checkbox"/> Hauled water <input type="checkbox"/> Other: _____			
What is the sewage system? <input type="checkbox"/> Municipal sewer <input type="checkbox"/> Septic tank <input type="checkbox"/> Other: _____			
Were there any water or sewer problems in the 2 months prior to your child's illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk      If yes, which body of water and date:			

<b>PATIENT EXPOSURES: FOOD</b>	
Does your child follow any special diets or eat certain types of food? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	



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<i>Food item</i>	<i>Frequency of consumption (at least once per day, per week, per month, less often, or never)</i>
Infant formula, if yes, brand:	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Baby food “pouches” (e.g., fruit, veggie, oatmeal, yogurt), if yes, brand(s):	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Other “toddler” foods (e.g., “puffs”)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Honey	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Soft cheeses (e.g., queso fresco, feta, blue cheese)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Yogurt, milk, or other dairy products	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Unpasteurized (“raw”) milk or other dairy product	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Uncooked/raw vegetables	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Fresh or frozen berries	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Fresh herbs or sprouts	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Mushrooms or mushroom powder	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Fish or shellfish	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Meat or poultry	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Herbal teas	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Bottled water <i>Probe for “Real Water” brand bottled alkaline water</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Foods brought from another country, if yes, specify:	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> Unk
Other food item of note not mentioned above. If yes, specify:	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> 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:

**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:

**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:

**SOCIOECONOMIC STATUS**

What type of health care insurance does the child currently have? (check all that apply)	<input type="checkbox"/> Private (e.g. HMO, PPO, managed care plan) <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid/state assistance program <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____
What is the highest grade or year of school completed by the child's parent/guardian?	<input type="checkbox"/> No high school <input type="checkbox"/> Some college <input type="checkbox"/> Some high school <input type="checkbox"/> College graduate

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CASE ID:-----

	<input type="checkbox"/> High school graduate/GED <input type="checkbox"/> Technical school	<input type="checkbox"/> Postgraduate/professional <input type="checkbox"/> Unknown/refused
<p>In your [<i>participant's name</i>] home, what is the annual household income before taxes for the last calendar year from all sources, including social security and pensions? [read options]</p>	<input type="checkbox"/> Less than \$25,000 <input type="checkbox"/> Between \$25,000 to <\$50,000 <input type="checkbox"/> Between \$50,000 to <\$75,000	<input type="checkbox"/> \$75,000 or more <input type="checkbox"/> Unknown/refused