Attachment C. Pediatric Hepatitis of Unknown Etiology - Exposures Questionnaire CONTROL (Parental Interview)

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

CONTROL ID:______________________________ MATCHED 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.

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 CDC on an investigation of children with hepatitis (severe liver inflammation). We received your name from [insert name of clinician and hospital] and we understand that your child does **not** have hepatitis. As part of this investigation, we are gathering information from children who had hepatitis and from those who don't, such as your child. Having a comparison group of children without hepatitis will help us learn more about what might be causing the children with hepatitis to become sick. During this conversation, which might take about 45 minutes, I will be asking for more detail about your child's general health status and their activities and diet leading up to the time they recently sought care. I will also ask about the other people living in your home and whether they had any illnesses recently. 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).

PEDIATRIC HEPATITIS OF UNKNOWN ETIOLOGY EXPOSURES QUESTIONNAIRE (PARENTAL INTERVIEW)

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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):	

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:

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.

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 before [INSERT DATE THE CHILD SOUGHT CARE].

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):

ELICITATION OF SPECIFIC MEDICATIONS

In the 2 months prior to [INSERT DATE THE CHILD SOUGHT CARE], 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), etc.)

Medication / Drug	*First date given (mm/yyyy)*	*Frequency*[1]	*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 [INSERT DATE THE CHILD SOUGHT CARE]? ☐ 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 [INSERT DATE THE CHILD SOUGHT CARE] 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 [INSERT DATE THE CHILD SOUGHT CARE]. ☐ 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 [INSERT DATE THE CHILD SOUGHT CARE]? ☐ Yes ☐ No ☐ Unk			
Location on body	*Date (mm/dd/yyyy)*	*Facility name*	

PATIENT HISTORY OF ILLNESS

What was the reason your child was receiving medical care when you were approached about this study?:	☐ Tonsillectomy ☐ Ear tubes (Tympanostomy) ☐ Infectious ilness, specify __________ ☐ Other surgical procedure, specify ____________ ☐ Chronic illness, specify ______________________ ☐ Injury, specify_____________________________ ☐ Other, specify ______________________________

Did your child experienced any of the following symptoms in the 2 weeks before they sought care?

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			

If yes, which was the first symptom to appear?		
If yes, approximately when did your child's symptoms begin? (mm/dd/yyyy): ___ ___ / ___ ___ / ___ ___ ___ __		
If yes, did you give your child any over-the-counter medications or home treatments for this illness? ☐ Yes ☐ No ☐ Unkn		
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): ___ ___ / ___ ___ / ___ ___ ___ __

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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): ___ ___ / ___ ___ / ___ ___ ___ __	

PATIENT EXPOSURES: SCHOOL / DAYCARE / EXTRACURRICULARS

Did your child attend in-person school or daycare (including informal daycare arrangement) in the month before [INSERT DATE THE CHILD SOUGHT CARE]? ☐ 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 [INSERT DATE THE CHILD SOUGHT CARE]? ☐ 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?

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 [INSERT

DATE THE CHILD SOUGHT CARE]. 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)*

PATIENT EXPOSURES: TRAVEL

In the 2 months before [INSERT DATE THE CHILD SOUGHT CARE], 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)*

In the 2 months before [INSERT DATE THE CHILD SOUGHT CARE], did any other household member travel away from home (any destination)? ☐ Yes ☐ No ☐ Unknown

Relationship to case	*Destination*	*Dates*	*Length*	*Anything unusual? (see above)*

PATIENT EXPOSURES: ANIMALS AND INSECTS

Did you have any pets or other animals living on your property in the 2 months before [INSERT DATE THE CHILD SOUGHT CARE]?

☐ 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*

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	☐ 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	
In the 2 months before [INSERT DATE THE CHILD SOUGHT CARE], 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 [INSERT DATE THE CHILD SOUGHT CARE], 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 [INSERT DATE THE CHILD SOUGHT CARE], 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 [INSERT DATE THE CHILD SOUGHT CARE], 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:			

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 [INSERT DATE THE CHILD SOUGHT CARE]? ☐ Yes ☐ No ☐ Unk

If yes, what:

In the 2 months prior to [INSERT DATE THE CHILD SOUGHT CARE], 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 [INSERT DATE THE CHILD SOUGHT CARE], 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

Did your child have any notable changes to their diet in the month before [INSERT DATE THE CHILD SOUGHT CARE]? (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 [INSERT DATE THE CHILD SOUGHT CARE], 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 [INSERT DATE THE CHILD SOUGHT CARE], 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 [INSERT DATE THE CHILD SOUGHT CARE]? ☐ Yes ☐ No ☐ Unsure If yes, specify:
Did your child ever eat alcohol-based hand sanitizer before [INSERT DATE THE CHILD SOUGHT CARE]? ☐ Yes ☐ No ☐ Unknown If yes, specify date and what happened:

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