Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/XXXX

ATTACHMENT 3. INITIAL CLINCAL AND SOCIAL SURVEY

Today's Date: _____/_____/_____ Interviewer Name: _____

Investigation ID: _____

County of residence: _____ State of residence: _____

What sex were you assigned at birth, on your original birth certificate?

o Female o Male o Other o Prefer not to answer/decline

How do you currently describe yourself? (check all that apply)

o Female o Male o Transgender o Prefer not to answer/decline

o I use a different term: _____

What is your race and/or ethnicity? *Select all that apply and enter additional details in the spaces below.*

o American Indian or Alaska Native – *Provide details below. Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.*

_____

o Asian – *Provide details below.*

o Chinese o Asian Indian o Filipino o Vietnamese
o Korean o Japanese
If needed: enter, for example, Pakistani, Hmong, Afghan, etc

_____

o Black or African American – *Provide details below.*

o African American o Jamaican o Haitian o Nigerian
o Ethiopian o Somali
If needed: enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc

_____

o Hispanic or Latino – *Provide details below.*

o Mexican o Puerto Rican o Salvadoran o Cuban
o Dominican o Guatemalan
If needed: enter, for example, Colombian, Honduran, Spaniard, etc

_____

o Middle Eastern or North African – *Provide details below.*

o Lebanese o Iranian o Egyptian o Syrian
o Iraqi o Israeli
If needed: enter, for example, Moroccan, Yemeni, Kurdish, etc

_____

o Native Hawaiian or Pacific Islander – *Provide details below.*

o Native Hawaiian o Samoan o Chamorro o Tongan

o Fijian o Marshallese

If needed: enter, for example, Chuukese, Palauan, Tahitian, etc

_____

o White – *Provide details below.*

o English o German o Irish o Italian

o Polish o Scottish

If needed: enter, for example, French, Swedish, Norwegian, etc

_____

We are going to ask you questions about the illness you had this year, for which you tested positive for Oropouche.

1) What date did your initial symptoms with this illness begin? (mm/dd/yyyy)
_____/_____/_____

2) Were you hospitalized during your initial illness? o Yes o No o Prefer not to answer

2a) If yes, for how many days? _____ days (dates of hospitalization if possible)

4a.1) Date of admission (mm/dd/yyyy):_____

4a.2) Date of discharge (mm/dd/yyyy):_____

2b) If yes, did you spend time in the intensive care unit (ICU)?

o Yes o No o Prefer not to answer

3) During your initial illness, what were your symptoms?

Fever o Yes o No o Unknown Highest temp: _____°F	Chills o Yes o No o Unknown	Headache o Yes o No o Unknown
Fatigue/malaise o Yes o No o Unknown	Muscle aches (myalgia) o Yes o No o Unknown	Joint pain (arthralgia) o Yes o No o Unknown
Back pain Yes o No o Unknown	Red eyes (conjunctival injection) o Yes o No o Unknown	Retroorbital or eye pain o Yes o No o Unknown
Light sensitivity (photophobia) o Yes o No o Unknown	Muscle weakness o Yes o No o Unknown	Seizures o Yes o No o Unknown
Stiff neck or neck pain o Yes o No o Unknown	Confusion o Yes o No o Unknown	Tremors/Shaking o Yes o No o Unknown
Numbness or tingling	Loss of appetite	Nausea

o Yes o No o Unknown	o Yes o No o Unknown	o Yes o No o Unknown
Vomiting o Yes o No o Unknown	Diarrhea o Yes o No o Unknown	Abdominal pain o Yes o No o Unknown
Sore throat o Yes o No o Unknown	Cough o Yes o No o Unknown	Shortness of breath o Yes o No o Unknown
Chest pain o Yes o No o Unknown	Painful urination (dysuria) o Yes o No o Unknown	Urinary incontinence o Yes o No o Unknown
Difficulty emptying bladder (retention) o Yes o No o Unknown	Painful ejaculation o Yes o No o Unknown o Not applicable	Scrotal and/or testicular pain (epididymitis, orchitis) o Yes o No o Unknown o Not applicable

Vaginal discharge (if applicable) o Yes o No o Unknown o Not applicable If yes, please describe:	Penile discharge (if applicable) o Yes o No o Unknown o Not applicable If yes, please describe:
Dizziness, lightheadedness, or vertigo o Yes o No o Unknown If yes, please describe:	Paralysis o Yes o No o Unknown If yes, please describe:
Rash o Yes o No o Unknown If yes, please describe:	Excessive sweating o Yes o No o Unknown

Hemorrhage (bleeding) [*List out all options below*]

o Yes o No o Unknown

If yes, then specify: o Nose bleeds o Bleeding gums o Blood in stool o Heavy or abnormal menstruation o Tiny spots of bleeding under the skin or mucous membranes (petechiae)

o Blood in urine (hematuria) o Blood in semen (hematospermia)

Other:

_____

4**)** Was there any point in your illness where your symptoms improved but then came back later?

o Yes o No o Unknown/Not sure

4a) If yes, how many times did this occur? _____ times

4b) If yes, if you can remember, what dates did your symptoms go away and then come back:

Remittance:_____ Relapse:_____

4b.1) If the patient has had multiple relapses, use table below:

Recurrence number	Remittance Date (improved)	Relapse date (worsened or recurred)
1		
2		
3		
4		
5		

4c) If yes, how would you describe the severity of the symptom relapse compared to your initial illness?

o More severe o Similar severity o Less severe o Unknown/Not sure

4d) If yes, please describe any relapsing symptoms that occurred, and whether this symptom reoccurred or was ongoing

Fever o Yes o No o Unknown Highest temp: _____°F o Recurrence, #: _____ OR o Ongoing symptom	Chills o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Headache o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Fatigue/malaise o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Muscle aches (myalgia) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Joint pain (arthralgia) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Back pain Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Red eyes (conjunctival injection) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Retroorbital or eye pain o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Light sensitivity (photophobia)	Muscle weakness	Seizures

o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Stiff neck or neck pain o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Confusion o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Tremors/Shaking o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Numbness or tingling o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Loss of appetite o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Nausea o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Vomiting o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Diarrhea o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Abdominal pain o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Sore throat o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Cough o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Shortness of breath o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Chest pain o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Painful urination (dysuria) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Urinary incontinence o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Difficulty emptying bladder (retention) o Yes o No o Unknown	Painful ejaculation o Yes o No o Unknown o Not applicable	Scrotal and/or testicular pain (epididymitis, orchitis) o Yes o No o Unknown o Not applicable

o Recurrence, #: _____ OR o Ongoing symptom	o Recurrence, #: _____ OR o Ongoing symptom	o Recurrence, #: _____ OR o Ongoing symptom

Vaginal discharge (if applicable) o Yes o No o Unknown o Not applicable If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom	Penile discharge (if applicable) o Yes o No o Unknown o Not applicable If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom
Dizziness, lightheadedness, or vertigo o Yes o No o Unknown If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom	Paralysis o Yes o No o Unknown If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom
Rash o Yes o No o Unknown If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom 5	Excessive sweating o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom

Hemorrhage (bleeding) [*List out all options below*] o Yes o No o Unknown If yes, then specify: o Nose bleeds o Bleeding gums o Blood in stool o Heavy or abnormal menstruation o Tiny spots of bleeding under the skin or mucous membranes (petechiae) o Blood in urine (hematuria) o Blood in semen (hematospermia) o Recurrence, #: _____ OR o Ongoing symptom
Other, please describe: o Recurrence, #: _____ OR o Ongoing symptom

4e) If yes, did you seek healthcare when these symptoms recurred?

o Yes o No o Prefer not to answer

4e.1) If yes, where did you seek care? Please provide dates if possible.

o Emergency department o Primary care doctor o Urgent care

o Other, specify:_____

Date(s) of care:_____

Next, we have some questions about your medical history.

5) Do you have any underlying medical conditions?

o Yes o No o Don't know/Not sure o Prefer not to answer

If yes, check any of the following conditions that apply.

o Asplenia (no spleen)

o Autoimmune disease (e.g., lupus, rheumatoid arthritis):
Describe_____

Medication(s):_____

o Blood problems (e.g., sickle cell disease):
Describe_____

o Diabetes mellitus: o Type I o Type II

o Cancer: Describe _____

Medication(s):_____

o Cardiovascular (heart or blood vessel) disease o Hypertension (high blood pressure)

o Chronic hepatitis or liver disease

o Chronic lung disease

o Immunosuppressive condition (any medical conditions that limit your ability to fight infections):

Describe_____

Medication(s):_____

o Renal (kidney) disease o On dialysis

o Other_____

_____

6) Do you take any medications that suppress your immune system?

o Yes o No o Unknown

7) In the 2 months before your illness, did you receive a blood transfusion or organ or tissue transplant?

o Yes o No o Unknown

7a) If yes, what did you receive (please provide dates)?

o Both o Blood transfusion only o Organ donation only o Unsure

Dates: _____

8) (*if applicable*) Are you currently pregnant or were you at any point during your illness?

o Yes o No o Unknown/Not sure

8a) If yes, at what point in gestation did you become ill? _____ months/weeks (*circle*)

8b) If yes, did you experience any complications such as stillbirth, spontaneous abortion, or fetal birth defects? o Yes o No o Unknown/Not sure

8c) If yes to 8b, please specify: _____

9) (*if applicable*) Are you currently breastfeeding?

o Yes o No

9a) (*If yes to 9*) Would you be willing to submit a sample of breast milk to test for Oropouche virus? [*Make sure information is also recorded in the consent*]

o Yes o No

9b) (*If yes to 9*) Did your baby travel with you on the trip before your illness?

o Yes o No

9c) (*If yes to 9*) Has your baby had any symptoms such as fever, loss of appetite, increased irritability, more sleepy, or rash since your illness (or around the time of your illness if the baby traveled)?

o Yes o No o Unknown/Not sure

o Other:_____

Note to interviewer: if their child has any worrisome symptoms, recommend they discuss with their pediatrician if Oropouche virus testing is appropriate.

10) ***If participant consented to sample collection and/or sexual history interview:***

(*if applicable*) Have you had a vasectomy?

o Yes o No o Unknown/Not sure

10a) If yes, when? (approximate month and year) _____

10b) If yes, did you have the vasectomy reversed? o Yes o No o Unknown/Not sure

10c) If reversed, when? (approximate month and year) _____

11) If the participant is male and participating in the sample collection investigation:

In the past 7 days, how many times did you ejaculate (not including ejaculation to collect a sample for this investigation)? _____

Finally, we are going to ask you some questions about travel and potential risks of exposure to Oropouche virus in the 2 weeks before your illness began.

12) During the 14 days before [*initial symptom onset*] were you traveling away from your home internationally?

o Yes o No o Unknown/not sure o Prefer not to answer

13) During the 14 days before [*initial symptom onset*] were you traveling away from your home within the US?

o Yes o No o Unknown/not sure o Prefer not to answer

14) If yes to Q8 or Q9, list **ALL** locations, including overnight transits and layovers:

Departure Date (MM/DD/YYYY)	Departure city, state/province/country	Arrival Date (MM/DD/YYYY)	Arrival city, state/province/country
Trip 1			
Trip 2			
Trip 3			
Trip 4			
Trip 5			

15) What **outdoor** activities did you do during your international trip? (in the 14 days before symptom onset) *[Check all that apply]*

c Sitting outdoors c Walking c Running c Hunting / fishing c Yard-work

c Hiking or camping c Playing

c Other (specify) _____ c Don't know

16) During what time periods did you typically spent more than 15 minutes outdoors doing these types of activities during your trip?

15a) Early morning (4am to 8am)	c Yes	c No	c Don't know
15b) Daytime (8am to 5pm)	c Yes	c No	c Don't know
15c) Evening (5pm to 9pm)	c Yes	c No	c Don't know
15d) Nighttime (9pm to 4am)	c Yes	c No	c Don't know

17) During your travel, how many hours per day did you typically spend outside?

o <1 hour o 1-4 hours o 5-8 hours o >8 hours

18) During your trip, in the 14 days before your illness began, do you recall any of the following?

Yes	No	Unknown	
o	o	o	Being bitten by a mosquito
o	o	o	Being bitten by a biting midge ("punkies" or "no-see-ums")

18a) **What time(s) of day did you get bitten by mosquitoes?**

Early morning (4am to 8am)	c Yes	c No	c Don't know
Daytime (8am to 5pm)	c Yes	c No	c Don't know
Evening (5pm to 9pm)	c Yes	c No	c Don't know
Nighttime (9pm to 4am)	c Yes	c No	c Don't know

18b) **What time(s) of day did you get bitten by midges?**

Early morning (4am to 8am)	c Yes	c No	c Don't know
Daytime (8am to 5pm)	c Yes	c No	c Don't know
Evening (5pm to 9pm)	c Yes	c No	c Don't know
Nighttime (9pm to 4am)	c Yes	c No	c Don't know

19) During your trip, how often did you do the following?

19a) Wear long sleeves and long pants when outside

c Always c Most of the time c Sometimes c Never c Don't know

19b) Wear insect repellant when outdoors for 15 minutes or more

c Always c Most of the time c Sometimes c Never c Don't know

[*If **NEVER** or **DK**, skip to **Q.19***]

19b.1) Do you recall the brand or active ingredient (such as DEET) of mosquito repellant that you usually use? _____ c Don't know

20) During the 14 days before your illness, did you have close contact (e.g. caring for, speaking with, touching, or having sex) with anyone who was recently sick with a similar illness?

c Yes c No c Don't know

20a) If yes, can you describe any contact you had with that person?

c Physical contact c Sexual contact c In close proximity

c Other, describe:_____

Thank participants for their time and willingness to provide information to help us learn more about Oropouche virus disease.