

ATTACHMENT 3. INITIAL CLINICAL 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?

- Female Male Other Prefer not to answer/decline

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

- Female Male Transgender Prefer not to answer/decline

I use a different term: _____

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

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.*

Asian – *Provide details below.*

- Chinese Asian Indian Filipino Vietnamese
 Korean Japanese

If needed: enter, for example, Pakistani, Hmong, Afghan, etc

Black or African American – *Provide details below.*

- African American Jamaican Haitian Nigerian
 Ethiopian Somali

If needed: enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc

Hispanic or Latino – *Provide details below.*

- Mexican Puerto Rican Salvadoran Cuban
 Dominican Guatemalan

If needed: enter, for example, Colombian, Honduran, Spaniard, etc

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

- Lebanese Iranian Egyptian Syrian
 Iraqi Israeli

If needed: enter, for example, Moroccan, Yemeni, Kurdish, etc

CDC estimates the average public reporting burden for this collection of information as 30 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 this burden to CDC/ATSDR CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

- Native Hawaiian or Pacific Islander – *Provide details below.*
 Native Hawaiian Samoan Chamorro Tongan
 Fijian Marshallese
If needed: enter, for example, Chuukese, Palauan, Tahitian, etc
-

- White – *Provide details below.*
 English German Irish Italian
 Polish 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? Yes No 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)?

Yes No Prefer not to answer

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

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

<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Vomiting <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Diarrhea <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Abdominal pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Sore throat <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cough <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Shortness of breath <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chest pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Painful urination (dysuria) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Urinary incontinence <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Difficulty emptying bladder (retention) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Painful ejaculation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable	Scrotal and/or testicular pain (epididymitis, orchitis) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable
Vaginal discharge (if applicable) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable If yes, please describe:	Penile discharge (if applicable) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable If yes, please describe:	
Dizziness, lightheadedness, or vertigo <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:	Paralysis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:	
Rash <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:	Excessive sweating <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Hemorrhage (bleeding) [<i>List out all options below</i>] <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, then specify: <input type="radio"/> Nose bleeds <input type="radio"/> Bleeding gums <input type="radio"/> Blood in stool <input type="radio"/> Heavy or abnormal menstruation <input type="radio"/> Tiny spots of bleeding under the skin or mucous membranes (petechiae) <input type="radio"/> Blood in urine (hematuria) <input type="radio"/> Blood in semen (hematospermia)		
Other: _____		

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

Yes No 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?

More severe Similar severity Less severe Unknown/Not sure

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

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

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

<input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	<input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	<input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Vaginal discharge (if applicable) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable If yes, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		Penile discharge (if applicable) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable If yes, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Dizziness, lightheadedness, or vertigo <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Paralysis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	
Rash <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Excessive sweating <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	
Hemorrhage (bleeding) [<i>List out all options below</i>] <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, then specify: <input type="radio"/> Nose bleeds <input type="radio"/> Bleeding gums <input type="radio"/> Blood in stool <input type="radio"/> Heavy or abnormal menstruation <input type="radio"/> Tiny spots of bleeding under the skin or mucous membranes (petechiae) <input type="radio"/> Blood in urine (hematuria) <input type="radio"/> Blood in semen (hematospermia) <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		
Other, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		

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

Yes No Prefer not to answer

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

Emergency department Primary care doctor Urgent care

Other, specify: _____

Date(s) of care: _____

Next, we have some questions about your medical history.

5) Do you have any underlying medical conditions?

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

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

Asplenia (no spleen)

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

Describe _____

Medication(s): _____

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

Describe _____

Diabetes mellitus: Type I Type II

Cancer: Describe _____

Medication(s): _____

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

Chronic hepatitis or liver disease

Chronic lung disease

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

Describe _____

Medication(s): _____

Renal (kidney) disease On dialysis

Other _____

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

Yes No Unknown

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

Yes No Unknown

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

Both Blood transfusion only Organ donation only Unsure

Dates: _____

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

Yes No 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? Yes No Unknown/Not sure

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

9) (if applicable) Are you currently breastfeeding?

Yes 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]

Yes No

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

Yes 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)?

Yes No Unknown/Not sure

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?

Yes No Unknown/Not sure

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

10b) If yes, did you have the vasectomy reversed? Yes No 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?

Yes No Unknown/not sure Prefer not to answer

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

Yes No Unknown/not sure 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]

- Sitting outdoors Walking Running Hunting / fishing Yard-work
- Hiking or camping Playing
- Other (specify) _____ 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) Yes No Don't know
- 15b) Daytime (8am to 5pm) Yes No Don't know
- 15c) Evening (5pm to 9pm) Yes No Don't know
- 15d) Nighttime (9pm to 4am) Yes No Don't know

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

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

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

- Yes No Unknown
- Being bitten by a mosquito
- 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 repellent 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 repellent 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.