# 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 – when you first got sick, 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  o Yes o No o Unknown | Loss of appetite  o Yes o No o Unknown | | Nausea  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)  o Yes o No o Unknown  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | Muscle weakness  o Yes o No o Unknown  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | | Seizures  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  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | Painful ejaculation  o Yes o No o Unknown o Not applicable  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | | Scrotal and/or testicular pain (epididymitis, orchitis)  o Yes o No o Unknown o Not applicable  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) When indoors, spent time in a place with screens or air conditioning

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

19b)Wear long sleeves and long pants when outside

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

19c) 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.***