

# Appendix D Epi Case Survey SAMPLE

For official interviewer use only

Form Approved  
OMB No. 0923-0051  
Exp XX/XX.XXXX

Household ID \_\_\_\_\_ Participant ID \_\_\_\_\_ Interviewer Initials \_\_\_\_\_ Interview location \_\_\_\_\_

## Confirmation of Identity (Please select one)

Social Security xxx - x \_ - \_\_\_\_\_

State ID: State \_\_ \_\_

Driver's license: State \_\_ \_\_

Number \_\_\_\_\_ exp \_\_ / \_\_ / \_\_\_\_\_

Number \_\_\_\_\_ exp \_\_ / \_\_ / \_\_\_\_\_

Other ID (describe) \_\_\_\_\_

## Registrant Information

1. Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_ 2. Date of Birth (mm/dd/yyyy) \_\_ / \_\_ / \_\_\_\_\_

3a Sex at birth (on birth certificate)  Male  Female

3b How do you currently describe yourself (mark all that apply)?

Male  Female  Transgender  I use another term (specify) \_\_\_\_\_

4.  Not pregnant  Pregnant à estimated due date (mm/dd/yyyy) \_\_ / \_\_ / \_\_\_\_\_

Don't know/refused  Other (specify) \_\_\_\_\_

## 4. Home Address

Street \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ 5. Email address \_\_\_\_\_

## 6. What social media accounts do you use? This helps us know how to best communicate with you. (check all that apply)

Facebook  Twitter  Instagram  Other \_\_\_\_\_  Refused

## 7. What are the best telephone numbers to reach you?

A. (\_\_\_\_) \_\_\_\_ - \_\_\_\_  Cell  Home  Work B. (\_\_\_\_) \_\_\_\_ - \_\_\_\_  Cell  Home  Work

## Emergency Contact Information (Prefer someone that lives at a different address)

8. Contact's Last name \_\_\_\_\_, First Name \_\_\_\_\_ MI \_\_\_\_\_

## 9. Contacts phone numbers

A. (\_\_\_\_) \_\_\_\_ - \_\_\_\_  Cell  Home  Work  B. (\_\_\_\_) \_\_\_\_ - \_\_\_\_  Cell  Home  Work

## 10. Contact's Address

Street \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ 11. Contact's Email address \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data 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 Clearance Officer, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30329

Same as residence check box  Skip to Q 13

Street \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ ZIP If unsure of address, nearest intersection/building/landmark \_\_\_\_\_

**13. Physical location during the incident (check all that apply)**

Inside building  Outside  Inside a car/vehicle  Other \_\_\_\_\_

**14. Do you think or were you told you were in contact with contaminants?**  Yes  No  Unsure

**15. Were told to decontaminate?**  Yes  No  Unsure

**16. Did you go to a Community Resource Center (CRC)?**  Yes  No  Unsure

**17. If you went to a Community Resource Center (CRC) what tracking number did they give you?**

\_\_\_\_\_

**18. Were you decontaminated (i.e. your clothing was removed and/or your body was washed, etc.)?**  Yes  No  Unsure

**19. Did you shelter-in-place?**  Yes  No  Unsure

**20. Did you evacuate?**  Yes  No  Unsure

**21. If you evacuated did you take any pets with you?**

Yes, I evacuated with all my pets  Yes, I evacuated some of my pets

No, I don't have any pets  No, I left them at home  Unsure

**22. As a result of this incident, are you personally in need of anything? (check all that apply)**

Medicine or medical supplies  Medical care  Mental health care  Water  Shelter  Food  Utilities

Transportation  Other, specify \_\_\_\_\_  Don't know/refused

**23. How many children younger than 18 years of age were in your immediate care during the incident** \_\_\_\_\_

(Note to survey developer, if electronic generate the corresponding number of children child 1-child N for Q21 and Q 22)

Child 1 Last name \_\_\_\_\_, First name \_\_\_\_\_ MI \_\_\_\_

b. Age (if less than 1, put 1) \_\_\_\_\_ c. Sex  Male  Female  Other Refuse/Unknown

**SYMPTOMS**

**24. Did you or your children have any of the following types of symptoms start or worsen after the incident?**

Answer each row of symptoms • <u>If nobody had symptoms check this box and go to the conclusion</u>	Self	Child 1	Child 2
Any symptoms affecting your whole body like fever, chills, weakness, or all over body aches/pains?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms affecting your eyes such as tearing, pain, burning or vision problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<b>Any symptoms related to your ears, nose and throat</b> such as pain in your ear, nose or throat, ringing in your ears, difficulty hearing, runny; stuffy, burning or bleeding nose or throat, or odor on your breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

[Type here]

<b>Any symptoms related to your skin</b> such as skin irritation, pain, burning, blistering, rash, discoloration, sweating, cuts, bruising bleeding or hair loss?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>Any symptoms related to your kidneys or urinary tract</b> like difficulty or pain with urinating, blood in your urine, or painful kidneys (often feels like lower back pain)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>Any symptoms related to your nervous system</b> such as headache, dizziness, seizures, numbness, loss of consciousness or balance, difficulty concentrating/remembering/or speaking?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>Any symptoms related to your heart and lungs</b> like breathing problems {including asthma, coughing or wheezing, pneumonia, bronchitis}; blood pressure and heart rate abnormalities; or chest tightness or pain?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>Any symptoms related to your muscles, joints, or bones</b> such as pain, weakness, tremors or twitching of muscles, joint swelling or pain, broken or dislocated bone, sprains or whiplash?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>Symptoms involving your mood, thought, or sleep</b> such as feeling anxious, afraid, irritable, hopeless, sad, tired, suspicious, trouble sleeping, or having hallucinations?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>Symptoms of your stomach or intestines</b> , such as nausea, vomiting or diarrhea, blood in your stool or vomit, abdominal pain, difficulties with bowel movements, or bowel perforation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure
<b>25 For radiological and nuclear incidents only</b> <b>If you had repeated vomiting after the incident, how long after the incident [date and time] did it start?</b>	<input type="radio"/> < 1 hour <input type="radio"/> 1-2 hours <input type="radio"/> 3-6 hours <input type="radio"/> > 6 hours <input type="radio"/> Unsure <input type="radio"/> No vomiting	<input type="radio"/> < 1 hour <input type="radio"/> 1-2 hours <input type="radio"/> 3-6 hours <input type="radio"/> > 6 hours <input type="radio"/> Unsure <input type="radio"/> No vomiting	<input type="radio"/> < 1 hour <input type="radio"/> 1-2 hours <input type="radio"/> 3-6 hours <input type="radio"/> > 6 hours <input type="radio"/> Unsure <input type="radio"/> No vomiting
<b>26. Did you or your children receive medical attention?</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure

Conclusion: Thank you for your time. Would you like a copy of this form  mailed or  emailed to you for your records?

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