Form Approved
OMB No. 0920-1446
Exp. Date: 3/31/2025

ATTACHMENT 3. INITIAL CLINCAL AND SOCIAL SURVEY

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 (0920-1446).

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

Investigation ID: _____

County of residence: _____ State of residence: _____

What is your sex?

o Female o Male

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):_____

o Unknown

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

o Unknown

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 o Yes o No o Unknown	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

(IF 1, go to 4b)

(IF >1, go to 4b.1)

4b) If once, 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	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	Diarrhea o Yes o No o Unknown	Abdominal pain o Yes o No o Unknown

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

If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom 5	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 (If yes, fill out 18a)
o	o	o	Being bitten by a biting midge ("punkies" or "no-see-ums") (If yes, fill out 18b)

18a) **What time(s) of day did you get bitten by mosquitoes? (Only if mosquito bites is yes)**

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? (Only if biting midges is yes)**

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.20***]

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.

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APPENDIX F. FOLLOW-UP ABBREVIATED CLINICAL SURVEY

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

Investigation ID: _____ Interview number:_____

1) Since our last interview, did you experience any ongoing symptoms or a relapse in symptoms?

o Yes, relapse o Yes, ongoing o No ***(if no, skip to 2 if applicable)*** o Unknown/Not sure

1a) If relapse, how many reoccurrences have you had before this one? (*use chart to determine and verify which reoccurrence this might be*)

o 1 o 2 o 3 o 4 o 5

1b) If relapse, if you can remember, what dates did your previous symptoms go away and then come back (if possible):

Remittance: _____ Relapse: _____

1c) If relapse, 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

1d) If ongoing, did the symptoms go away? o Yes o No o Unknown/Not sure

1d.1) If yes, what date? (mm/dd/yyyy):_____

1e) If yes, please describe any symptoms that recurred or continued:

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	Red eyes (conjunctival injection) o Yes o No o Unknown	Retroorbital or eye pain o Yes o No o Unknown

o Recurrence, #: _____ OR o Ongoing symptom	o Recurrence, #: _____ OR o Ongoing symptom	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	Painful ejaculation	Scrotal and/or testicular pain

(retention) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	o Yes o No o Unknown o Not applicable o Recurrence, #: _____ OR o Ongoing symptom	(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

1e) If yes, did you seek healthcare when these symptoms recurred?

o Yes o No o Unknown

1e.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:_____

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

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

If the patient has not experienced symptoms for 4 weeks, inform them that they have reached the endpoint of this part of the investigation and thank them for their participation. If the participant reported a relapse in symptoms, schedule a time to repeat the interview and thank them for their participation.