# 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  o Yes o No o Unknown  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | 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 (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.***

# 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  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 | | | |

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.***