

ID:

EPIDEMIOLOGIC QUESTIONNAIRE FOODBORNE DISEASE OUTBREAK INTENSIVE INVESTIGATION

THIS PAGE IS FOR ADMINISTRATIVE PURPOSES ONLY
TURN TO PAGE 2 FOR INTERVIEW AND QUESTIONNAIRE

Each time an attempt is made to contact the respondent, write down the date, time, and results of the call in the table below.

Call	Date	Time	Notes
1st Try			
2nd Try			
3rd Try			
4th Try			
5th Try			

**CIRCLE ONE RESPONSE
PRIOR TO HANDING IN
QUESTIONNAIRE.**

What is the status of the interview?

1. Interview was completed
2. Interview was not completed because:
 - a. Respondent refused to participate
 - b. Respondent has not returned messages
 - c. Still no answer after five attempts
 - d. Phone number is disconnected
 - e. Correct phone number is not known
3. Other (**specify** _____)

On what date was the interview conducted?

____ / ____ / 2000
Month Day Year

Name of Person to be interviewed _____ , _____
Last First

Work Phone Number (____) - ____ - ____

Home Phone Number (____) - ____ - ____

CDI #

SECTION A: INTRODUCTION AND SCREENING FOR ILLNESS

INTRODUCE SELF	Hello, my name is _____ and I'm calling from the Communicable Disease Program at the Chicago Department of Health.
WHY CALLING	We're following up on some cases of diarrheal illness that occurred in people who attended an EVENT A at PLACE X in Chicago on DATE Y .
INFORMATION NEEDED	I would like to ask you for some information related to the meal at that event, and about any illness you may have had following the event.
USE OF INFORMATION	This may take 20-30 minutes to complete, but the information you provide is essential to us finding out if there was something at the event that made people ill, and making sure that no other people are put at risk.
CONFIDENTIALITY	The information you provide will be kept confidential.

1	<i>Did you attend this event?</i> 1. Yes 2. No ⇒	1a	<i>Did you eat or taste any food or drinks from this event?</i> 1. Yes GO TO QUESTION 3 BELOW 2. No DETERMINE IF CONTACTS ATTENDED															
2	<i>Were there other people who went with you?</i> 1. Yes ⇒ 2. No	2a	FOR OTHER ATTENDEES, SPECIFY: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">Name</th> <th style="width: 30%; text-align: left;">Relationship</th> <th style="width: 40%; text-align: left;">Phone # (if different)</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>4. _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <div style="background-color: #cccccc; padding: 5px; margin-top: 5px;"> READ: We would like to talk to each of these people about what they ate and if they became ill. May I begin by getting some information from you? </div>	Name	Relationship	Phone # (if different)	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____
Name	Relationship	Phone # (if different)																
1. _____	_____	_____																
2. _____	_____	_____																
3. _____	_____	_____																
4. _____	_____	_____																
3	<i>Did you experience any symptoms of illness at any time following the event?</i> 1. Yes GO TO NEXT PAGE (ILLNESS SECTION) 2. No GO TO SECTION C (FOOD SECTION)																	

SECTION B: ILLNESS

READ:

I'd like you to take a moment and tell me about your illness.

<p>1 What was the FIRST SYMPTOM you experienced? _____ First symptom(s)</p>	⇒	<p>2 On what day and time did it BEGIN? _____ : _____ AM/PM DAY TIME</p>
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	Did you have:		How would you describe it?		On what day and time did it begin?		How long did it last?		At its worst, what was the most:
3	DIARRHEA or LOOSE STOOLS? 1. YES ⇒ 2. NO	3a	1. Watery 2. Bloody 3. Mucoid 4. Looser than Normal 5. Other [SPECIFY] _____	3b	_____ : _____ AM/PM DAY TIME	3c	_____ DAYS	3d	_____ STOOLS/24 Hrs.
4	VOMITING? 1. YES ⇒ 2. NO			4b	_____ : _____ AM/PM DAY TIME	4c	_____ DAYS	4d	_____ TIMES/24 Hrs.
5	FEVER? 1. YES ⇒ 2. NO			5b	_____ : _____ AM/PM DAY TIME	5c	_____ DAYS	5d	_____ DEGREES [If temp. not measured, write N.M.]
6	NAUSEA? 1. YES ⇒ 2. NO	6a	1. Severe 2. Moderate 3. Mild 9. Don't know						
7	ABDOMINAL CRAMPS? 1. YES ⇒ 2. NO	7a	1. Severe 2. Moderate 3. Mild 9. Don't know						
8	MUSCLE ACHES? 1. YES ⇒ 2. NO	8a	1. Severe 2. Moderate 3. Mild 9. Don't know						
9	Did you have ANY OTHER SYMPTOMS? ⇒ 1. YES [SPECIFY] _____ 2. NO			10	On what date did you feel that your health was back to normal? _____/_____/_____ Date [If health still not normal, write STILL.]				

	Did you visit a:		Name and phone # of hospital and/or provider?		Did you stay overnight?		Were you given IV fluids?
11	HOSPITAL or E.R.? 1. YES ⇒ 2. NO	11a	Name _____ Phone # _____ _____	11b	1. YES [SPECIFY] Date admitted _____ Date discharged _____ _____/_____/_____ 2. NO	11c	1. YES 2. NO

12	DOCTOR'S OFFICE ? 1. YES ⇒ 2. NO	12a	Name _____ Phone # _____ _____
13	OTHER MEDICAL PROVIDER ? 1. YES ⇒ 2. NO	13a	Name _____ Phone # _____ _____

14	Did you submit any SPECIMENS? 1. YES ⇒ 2. NO	14a	Where and when did you submit the specimen(s)? Doctor/Facility _____ Specimen type(s) _____ Collection date _____ _____/_____/_____	14b	What were the results? _____ _____
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15	Were you PRESCRIBED any medications? 1. YES ⇒ 2. NO	15a	What medications? _____
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16	How limited were your normal activities? 1. Very limited 2. Somewhat limited 3. Not limited at all ⇒	17	Did you stay home from work (or school)? 1. YES [SPECIFY # DAYS MISSED: _____] 2. NO 3. DOES NOT WORK OUTSIDE HOME
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6	FLOUR TORTILLA 1. Yes ⇒ 2. No 9. Don't know	6a	1. One tortilla or less 2. More than one but less than five tortillas 3. Five or more tortillas 9. Don't know
7	FRENCH BREAD 1. Yes ⇒ 2. No 9. Don't know	7a	1. Less than one slice 2. One whole slice 3. More than one slice 9. Don't know
There was a fresh vegetable tray with three vegetables and dipping sauces			
8	CELERY STALKS 1. Yes ⇒ 2. No 9. Don't know	8a	1. One stalk or less 2. More than one but less than five stalks 3. Five or more stalks 9. Don't know
9	CUCUMBER SLICES 1. Yes ⇒ 2. No 9. Don't know	9a	1. One slice or less 2. More than one but less than five slices 3. Five or more slices 9. Don't know
10	FRESH RED PEPPERS 1. Yes ⇒ 2. No 9. Don't know	10a	1. One slice or less 2. More than one but less than five slices 3. Five or more slices 9. Don't know
(There were 2 kinds of dipping sauces)		(Sauces were spooned onto plates)	
11	RED-PEPPER SAUCE 1. Yes ⇒ 2. No 9. Don't know	11a	1. One spoonful or less 2. More than one but less than five spoonfuls 3. Five or more spoonfuls 9. Don't know
12	COCONUT-PEANUT SAUCE 1. Yes ⇒ 2. No 9. Don't know	12a	1. One spoonful or less 2. More than one but less than five spoonfuls 3. Five or more spoonfuls 9. Don't know
13	ARTICHOKES 1. Yes ⇒ 2. No 9. Don't know	13a	1. One petal (piece) 2. More than one but less than five petals (pieces) 3. Five or more petals (pieces) 9. Don't know
14	VINAGRETTE DIP-SAUCE (for artichokes) 1. Yes ⇒ 2. No 9. Don't know	14a	1. One spoonful or less 2. More than one but less than five spoonfuls 3. Five or more spoonfuls 9. Don't know

15	BLACK BEAN SALSA (with corn and tomatoes) 1. Yes ⇒ 2. No 9. Don't know	15a	1. One bite or less 2. More than one but less than five bites 3. Five or more bites 9. Don't know
There were several different fresh fruits			
16	WATERMELON 1. Yes ⇒ 2. No 9. Don't know	16a	1. One wedge or less 2. More than one but less than five wedges 3. Five or more wedges 9. Don't know
17	CANTALOUPE 1. Yes ⇒ 2. No 9. Don't know	17a	1. One wedge or less 2. More than one but less than five wedges 3. Five or more wedges 9. Don't know
18	PINEAPPLE 1. Yes ⇒ 2. No 9. Don't know	18a	1. One wedge or less 2. More than one but less than five wedges 3. Five or more wedges 9. Don't know
19	HONEYDEW MELON 1. Yes ⇒ 2. No 9. Don't know	19a	1. One wedge or less 2. More than one but less than five wedges 3. Five or more wedges 9. Don't know
There were 3 kinds of cakes and two other desserts			
20	STRAWBERRY CAKE (pink icing) 1. Yes ⇒ 2. No 9. Don't know	20a	1. One bite or less 2. More than one bite but less than one slice 3. One whole slice 4. More than one slice 9. Don't know
21	WHITE CAKE (white icing) 1. Yes ⇒ 2. No 9. Don't know	21a	1. One bite or less 2. More than one bite but less than one slice 3. One whole slice 4. More than one slice 9. Don't know
22	CARROT CAKE 1. Yes ⇒ 2. No 9. Don't know	22a	1. One bite or less 2. More than one bite but less than one slice 3. One whole slice 4. More than one slice 9. Don't know

23	CHOCOLATE BROWNIES 1. Yes ⇒ 2. No 9. Don't know	23a	# OF BROWNIES? _____
24	CHOCOLATE MOUSSE 1. Yes ⇒ 2. No 9. Don't know	24a	1. One spoonful or less 2. More than one but less than five spoonfuls 3. Five or more spoonfuls 9. Don't know
[Some of the drinks that were available were strawberry lemonade, iced tea, hibiscus tea (cold), and mineral water.]			
25	What did you have to drink? Name of Drink # How served Ice? (glass,can,bottle,etc.) 1. _____ _____ _____ _____ 2. _____ _____ _____ _____ 3. _____ _____ _____ _____ 4. _____ _____ _____ _____		FOR EACH DRINK: WRITE DOWN THE NAME OF THE DRINK, THE NUMBER CONSUMED, HOW IT WAS SERVED (GLASS CAN, BOTTLE), AND IF ICE WAS ALSO CONSUMED.
26	Did you eat or taste any foods that I haven't already mentioned, such as condiments, sauces, desserts, snacks, fruits, or garnishes? Name of Food How served How much 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____ 4. _____ _____ _____		ASK FOR: NAMES OF FOODS, DESCRIPTIONS OF HOW SERVED, AND QUANTITY CONSUMED
27	Do you have any leftover foods from the event? 1. Yes ⇒ 2. No	27a	May an investigator come out to your home to pick up this food? LOCATION: _____ DATES: _____ TIMES: _____
28	Do you know of anyone who ate foods from the event but did not attend (such as someone who ate leftovers at home)? 1. Yes ⇒ 2. No	28a	Contact information for these individuals: Name Phone # ILL?(Y/N)

SECTION D: DEMOGRAPHICS

READ: To finish, I'd like to ask you for some information on your medical history and demographics. (This is confidential.)

1	Are there any foods that cause you to have problems (allergy, intolerance)? 1. Yes [SPECIFY FOOD/REACTION] _____ 2. No 9. Don't know																																										
2	At the time of the event, were you taking any of these kinds of treatments? [CIRCLE ALL TAKEN] 1. Antibiotics 2. Antacids 3. Steroids 4. Chemotherapy ⇒	2a	FOR ALL TREATMENTS, SPECIFY: Name of Treatment Reason for taking Dose taken _____ _____ _____																																								
3	Have you ever had any of these medical conditions? [CIRCLE ANY CONDITIONS REPORTED AND SPECIFY DETAILS] <table style="width: 100%; border: none;"> <tr> <td style="width: 35%;"></td> <td style="width: 25%; text-align: center;">Type of condition</td> <td style="width: 25%; text-align: center;">Year of diagnosis</td> <td style="width: 15%; text-align: center;">Currently receiving treatment?</td> </tr> <tr> <td>1. Diabetes</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2. Cancer</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3. Peptic ulcer</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>4. Heart disease</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>5. Liver or Kidney disease</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>6. Stomach surgery</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>7. Organ transplant</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>8. Suppressed Immune System</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>9. Chronic diarrhea</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>				Type of condition	Year of diagnosis	Currently receiving treatment?	1. Diabetes	_____	_____	_____	2. Cancer	_____	_____	_____	3. Peptic ulcer	_____	_____	_____	4. Heart disease	_____	_____	_____	5. Liver or Kidney disease	_____	_____	_____	6. Stomach surgery	_____	_____	_____	7. Organ transplant	_____	_____	_____	8. Suppressed Immune System	_____	_____	_____	9. Chronic diarrhea	_____	_____	_____
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4	What is your AGE? ____ ____ Years																																										
5	SEX 1. Male 2. Female ⇒	5a	CURRENTLY PREGNANT? 1. Yes 2. No																																								
6	RACIAL/ETHNIC BACKGROUND? 1. African-American or Black 2. Caucasian or White 3. Hispanic or Latino 4. Asian or Pacific Islander 5. Native American or Alaskan 6. Other (specify _____) 8. Refused 9. Don't know																																										
7	OCCUPATION _____ IF SENSITIVE OCCUPATION ⇒	7a	PLACE OF WORK Name: _____ Location: _____																																								