

Generic Questionnaire

(bank of questions to choose from in order to prepare a specific questionnaire)

Demographics: (For descriptive data analysis and ability to track case for follow up)

Last Name: _____ First Name _____ Age in years _____ Date of birth _____
 Identifying Number _____ Check only one: SSN Drivers license #)
 Sex: Male Female
 Home address: Street _____ Apt _____ City _____ Zip Code _____
 Home telephone (____)____-____ Mobile (____)____-____ Other # (____)____-____ Other # (____)____-____
 Name of a contact person: _____ Relationship _____
 Contact Phone () - Other # () - Address _____

Occupation: (To evaluate occupational diseases)

Place of Employment _____ Brief Job Description _____
 Department _____ Floor _____ Office # _____ Work phone # (____)____-____
 Lab worker /technician* - Taxidermist*
 Work with animal: Veterinarian Farmer Abattoir worker Butcher Other food preparation

Travel history (To evaluate if case was imported or indigenous)

for past month (or if specific disease is suspected restrict to longer incubation period)
 List dates, place, mode of transportation

Hobby: (to identify hobby related disease: anthrax and other zoonosis)

Work with fibers /wool /animal skin /any animal product Yes* No
 Camping in past month Yes* No - Stayed in cabins Yes* No
 Hunter Yes* No - Skinned or dressed animal Yes* No - Had animal stuffed Yes* No

Pets: (to identify zoonosis)

Dog Cat Rabbit Other
 Cared for sick animal: Yes No – If yes describe:

Contact with wild animal: Type of animal

Explain circumstances

Food consumption :

(This section is specific to anthrax, brucellosis and other zoonotic diseases contracted from food)

Consumption of unusual meats: Buffalo Bear Venison Other _____ None
 Cooking of meat listed above: raw jerky cooked, rare cooked, medium cooked, well done
 Consumption of home canned foods Yes* No
 Consumption of Raw milk Unpasteurized milk Unpasteurized cheese None

Medical History					
Do you have a regular doctor? If yes, Name _____ Phone (____)____-____					
Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No *List _____					
Any wound /lesion on skin in past months <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____ Appearance _____					
Intestinal surgery <input type="checkbox"/> Yes <input type="checkbox"/> No - Inflammatory bowel syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No -					
Allergic to Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No *List _____					
Diabetes	Y N U	<input type="checkbox"/> oral meds <input type="checkbox"/> insulin	Cardiovascular	Y N U	→
Renal failure	Y N U	→	Pulmonary disease	Y N U	→
Malignancy	Y N U	→	Immunosuppression	Y N U	→
Pregnancy	Y N U				
Other underlying conditions: → _____					
Onset: Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Date symptoms started _____ Time _____					
Signs and Symptoms Circle best answer	Onset	Signs and Symptoms Circle best answer	Onset	Describe	
Headache	Y N U	Muscle aches	Y N U	Location:	
Joint pain	Y N U				
Chills	Y N U	Fever	Y N U	Highest temp:	
Nausea	Y N U	Diarrhea	Y N U	# stools/day:	
Vomiting	Y N U	Stomach pain	Y N U	Excessive salivation	Y N U
Conjunctivitis, eye irritation	Y N U	Runny nose	Y N U		
Cough, dry, hacking	Y N U	Sputum, productive cough	Y N U	<input type="checkbox"/> Purulent <input type="checkbox"/> Bloody <input type="checkbox"/> Frothy	
Shortness of breath	Y N U	Difficulty breathing	Y N U	Hx of asthma	Y N U
Stridor, wheezing	Y N U	Cyanosis	Y N U		
Coma: does not respond	Y N U	Stupor: respond to voice	Y N U	Dizziness	Y N U
Drowsiness: eyes closed	Y N U	Confusion: awake	Y N U		
Blurred vision	Y N U	Muscle paralysis	Y N U	Location:	
Droopy eyelid	Y N U	Difficulty swallowing	Y N U		
Difficulty speaking	Y N U	Ataxia, coordination	Y N U		
Photophobia	Y N U	Stiff neck	Y N U		
Metallic taste in mouth	Y N U	Pupils react to light	Y N U	Pupils <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Normal	
Excessive sweating	Y N U	Muscle twitching	Y N U		
Vesiculo pustular rash	Y N U	Rash: Other	Y N U	Describe:	
Hemorrhagic rash	Y N U	Skin ulcer	Y N U	Describe:	
Sunburn, redness, itching	Y N U	Blisters	Y N U	Bullous lesions	Y N U

Hospitalization <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Hospital		
Date of admission	Date of discharge		
Physician name	Office phone	Pager	Fax
Admission diagnosis			
Physical exam (note abnormalities)			
Chest Xray			
Significant diagnostic studies			
Treatment			
ICU stay (days) Mechanical ventilation Y N			
Discharge diagnosis			
Outcome <input type="checkbox"/> discharged/recovered <input type="checkbox"/> long term care <input type="checkbox"/> died			