



Legionellosis Questionnaire

State ID _____

Date: _____ Interviewer: _____

Interviewer Phone: (____) _____

Interviewer Email: _____

Health Dept: _____

Patient's outcome:

RECOVERED

STILL ILL

DIED

Introduction: Hello, my name is _____ and I am calling from _____. I'm calling about your recent Legionnaires' disease. Legionnaires' disease is a reportable disease, which means that healthcare providers must report cases to public health to determine if there is a public health concern. I'd like to ask you a few questions about your exposures during the 10 days before you got sick. You do not have to answer the questions, but your cooperation is appreciated. Do you have a few minutes to talk? If not, when would be a good time for me to call back? _____

Patient's Name (Last, First): _____ **Age:** _____ **Sex:** Male Female

Address (City, State, Zip): _____ **County:** _____

Daytime Phone: _____ **Evening Phone:** _____

Surrogate Contact Info <if patient unwell or has died>. **Relationship** to patient _____

Name (Last, First): _____ **Age:** _____ **Sex:** Male Female

Address (City, State, Zip): _____ **County:** _____

Daytime Phone: _____ **Evening Phone:** _____

When did you first start feeling sick? Symptom onset (Date, time): _____



Exposure information:

<I'd like to ask you some questions about your travel and exposure during the **10 days before** you got sick. The time period is between ____ and ____ (See above). During these 10 days, did you do the following?> [Y = Yes, N = No, DK = Don't know]

Y N DK

Visit or work in a hospital?

Inpt Outpt Visitor Employee Volunteer

Dates: _____

Name/City Hosp: _____

Comments: _____

Visit a doctor's office, clinic, or dentist's office?

Doctor's office/clinic Dentist

Dates: _____

Name of doctor/clinic: _____

Location (City): _____

Comments: _____

Visit, reside, or work in long-term care facility, nursing home, assisted living facility, or senior living facility?

Resident Visitor Employee

Dates: _____

Name of facility: _____

Type: Long term facility/Skilled Nursing

Assisted Living

Senior Living/Retirement home

Location (City): _____

Comments: _____

Y N DK

Traveled during 10 day period before getting sick, or stayed overnight somewhere other than his/her usual residence?

Date of Stay (Arrival-Departure): _____ -- _____

Name of place: _____ Rm No: _____

Address: _____

City/State/Country: _____

Comments: _____

Date of Stay (Arrival-Departure): _____ -- _____

Name of place: _____ Rm No: _____

Address: _____

City/State/Country: _____

Comments: _____

Visit a hotel without staying overnight (dinner, wedding)?

Date of Stay (Arrival-Departure): _____ -- _____

Name of place: _____

Address: _____

City/State: _____

Comments: _____

Y N DK

Attend any conventions or public gatherings?
 Type of Event: _____
 Date (s): _____
 Name of place: _____
 Address: _____
 City/State/Country: _____
 Comments: _____

Within the 10 days before getting sick, had exposure to any of the following: <Record Location/Date on line>
 Hot tub OR whirlpool spa
Location/Date: _____
 Sat NEAR working hot tub, or whirlpool spa but did Not get in _____
 Jacuzzi _____
 Pool _____
 Recreational Mister _____
 Steam room or wet sauna _____
 Decorative fountain _____
 Humidifier _____
 Shower (away from home only)
 Comments: _____

Used nebulizer, CPAP, BiPAP, or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma, or for any other reason?
 Type: _____
 Date: _____

Does device use humidifier or misty water?
 Describe type of water used (sterile, distilled, tap), and how it is cleaned: _____

Recalled any general construction, plumbing projects, water main breaks, or water line work either at your home or while traveling in those 10 days?
 Type of work: _____
 Date(s): _____
 Location: _____
 Comments: _____

Within the 10 days before getting sick, shopped at a grocery store that had water mister machines for the fruits/vegetables?
 Name of Store: _____
 Date(s): _____
 Location: _____
 Comments: _____

Name of Store: _____
 Date(s): _____
 Location: _____
 Comments: _____

Shopped at mall or any other store?
 Name of Store: _____
 Date(s): _____
 Location: _____
 Comments: _____

Name of Store: _____
 Date(s): _____
 Location: _____
 Comments: _____

Y N DK

Work or volunteer full or part-time?
 Job Description: _____
 Company: _____
 Location: _____
 Exposure to mist water? _____

Job Description: _____
 Company: _____
 Location: _____
 Exposure to mist water _____

Know anyone with similar symptoms?
 Name: _____
 Phone: _____
 State of residence: _____
 Detail of shared exposure: _____

Name: _____
 Phone: _____
 State of residence: _____
 Detail of shared exposure: _____

Name: _____
 Phone: _____
 State of residence: _____
 Detail of shared exposure: _____

MEDICAL HISTORY

Have you ever been told by a health care provider that you had:

Y N DK

- Chronic Kidney Disease _____
- Cancer/Leukemia _____
- Chemotherapy _____
- HIV _____
- Organ transplant _____
- Steroid therapy _____
- Diabetes _____
- COPD or Emphysema _____
- Asthma _____
- Heart Disease or CHF _____
- Liver Disease _____
- Other _____

HEALTH BEHAVIORS:

<Are you currently doing any of the following?>

- Smoker? Packs per day: _____ x Yrs _____
- Former Smoker? Packs per day: _____ x Yrs _____
 When did you quit: _____
- Drink alcohol? Drinks per day: _____ x Yrs _____

<This is the end of the questionnaire! Thank you for your time. Do you have any questions about Legionnaires' disease that I can help answer? If you have any questions or remember any further details, you may reach me at _____. Thank you!>