



Infectious Disease Epidemiology Section  
Office of Public Health, Louisiana Dept of Health & Hospitals  
(504) 219-4563 or 800-256-2748 (after-hours emergency)  
[www.infectiousdisease.dhh.louisiana.gov](http://www.infectiousdisease.dhh.louisiana.gov)

## **Unspecified Neurological Syndrome**

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### **EPIDEMIOLOGY**

Several pathogens identified as possible agents of bioterrorism could cause patients to present with a rash and an accompanying fever. Since there is only a small chance of knowing what agent is causing an event there is clearly a need to plan to respond to diseases caused by unknown agents. The list of likely bioterrorism agents that could cause a respiratory type illness includes smallpox and several different viral hemorrhagic fevers (VHF). Additionally some arboviruses and several other diseases of public health concern have the ability to cause syndromes that include a rash and a fever.

### **CLINICAL FEATURES**

Signs and Symptoms: Clinical manifestations of the different diseases that might be considered would present with a rash with accompanying fever. This combination of clinical features is however, not particularly useful without considering the patient demographics, the seasonal and geographic distribution of respiratory diseases, and course that the illness takes. The primary clinical presentation that should alert a clinician is that the case or cases appear to be distinctly unusual in some respect.

### **DIAGNOSIS**

Specific diagnosis for each of the diseases that could be considered likely bioterrorism agents or agents of public health concern will differ depending on the etiologic agent. Although laboratory confirmation will be sought in the event of any disease event reported to the Infectious disease epidemiology section, this particular plan assumes that the laboratory confirmation leading to a definitive diagnosis is delayed or in some other way impeded. As such clinical diagnosis of one or more unusual respiratory infections with the potential to threaten the public's health will be the basis for follow-up.

### **SURVEILLANCE**

The key to effective surveillance of unusual infectious diseases is the astute clinician. It is through continuing medical education and regular trainings with Louisiana's medical community that clinicians will be sensitized to and informed about unusual disease events and their role in identifying these events. Furthermore, the Louisiana Sanitary Code requires the reporting of any case of rare or exotic communicable diseases, unexplained death, unusual cluster of disease.

### **CASE MANAGEMENT**

Treatment: Upon determination of the etiology of the disease appropriate case management guidelines will be developed and communicated to the medical community. Additionally, information pertinent to the control of transmission will be communicated to all of the susceptible audiences.

## **CASE DEFINITION**

Following the data gathering interviews that will be conducted early in the investigation a clinical case definition will be developed in order to identify cases that have a common set of signs and symptoms.

## **PROPHYLAXIS**

The administration of prophylaxis will be dependent on the organism that it identified as the causative agent.

## **ISOLATION**

Contact, droplet or airborne precautions will be considered and recommended based on the information available and on the risks and benefits that may accompany the decision.

Isolation = separation and confinement of individuals known or suspected (via signs, symptoms or lab criteria) to be infected with a contagious disease to prevent transmission

Containment measures:

- Travel restrictions: public transportation
- Restrictions on public gatherings

## **Infectious Disease Epidemiology: Epidemiologic Response Checklist**

### **Consultation/ Confirmation**

- Discuss bioterrorism event definitions with key public health personnel (health officer, communicable disease control staff, laboratorians, etc.)

### **Laboratory Confirmation**

- Identify point of contact (POC) at appropriate state public health laboratory in a potential bioterrorist event

### **Notification**

- Establish local notification network to be activated in case of a possible bioterrorist event; disseminate contact information and notification protocol
- Establish relationships with local Office of Emergency Preparedness and FBI contacts to be notified in a suspected bioterrorist event and maintain up-to-date contact information

### **Coordination**

- Establish Epidemiologic Response as a part of local Incident Command System
- Identify personnel available for epidemiologic investigation and perform inventory of skills and duties
- Establish contacts at regional and Parrish health units identify potential personnel resources available for epidemiologic “mutual aid”
- Establish contacts at the local FBI office for coordination with epidemiologic/ criminal Investigation

### **Communication**

- Identify epidemiologic investigation spokesperson and Public Information Officer (PIO)
- Establish communication protocol to be implemented during an epidemiologic investigation between PIO and epidemiologic investigation spokesperson
- Establish a plan for rapid dissemination of information to key individuals: FAX, Email, website on the internet (if capability exists)

### **Epidemiologic Investigation**

#### **A. Case Finding**

- Establish plans/ capacity to receive a large number of incoming telephone calls
- Develop telephone intake form
- Identify individuals available to perform telephone intake duties
- Identify potential reporting sources (persons/ facilities) to receive case definition
- Establish a plan for rapid dissemination of case definition to potential reporting sources

#### **B. Case Interviews**

- Obtain appropriate case investigation questionnaires
- Identify personnel available to conduct case interviews
- Establish a protocol for training case interviewers
- Obtain template outbreak disease-specific investigation questionnaires

### **C. Data Analysis**

- Obtain template database for data entry
- Assure Epi Info software is installed on data entry computers
- Identify personnel available for data entry
- Identify personnel with skills to perform descriptive and analytic epidemiologic analysis
- Develop/ obtain data analysis plan
- Develop/ obtain outbreak investigation monitoring tool

### **Contact Tracing**

- Establish a system for locating contacts and familiarize personnel with contact tracing protocol(s)
- Obtain Contact Tracing Forms
- Obtain contact management algorithms for diseases that are communicable from person-to-person
- Obtain treatment/ prophylaxis guidelines
- Develop local drug and vaccine distribution plan
- Establish a system for daily monitoring of all contacts under surveillance

### **Public Health Recommendations**

- Obtain treatment and prophylaxis recommendations for bioterrorist threat agents
- Develop or obtain bioterrorist disease-specific fact sheets
- Establish contact with key health care providers/ facilities and establish protocol for rapid dissemination of recommendations regarding treatment, prophylaxis, personal protective equipment, infection control, and isolation/ quarantine

### **Consultation / Confirmation**

- Disease scenario meets the bioterrorist event definition

### **Laboratory Confirmation**

- Lab specimens are en route to the local public health laboratory/ Laboratory Response Network

### **Notification**

- Department of Health and Human Services
- State Medical Officer
- (225)342-3417 (regular business hours)
- (800)990-5366 pin 6710 (pager for evenings, weekends, holidays)
- State Epidemiologist (504)458-5428 Mobile
- Public Health Lab (504)568-5371
- Public Health Lab Pager (800)538-5388
- OPH Regional Offices (Internal Notification Network)
- Louisiana EOC (225)-925-7500
- Louisiana State Police (800)469-4828 (Crisis Management Center)

**Coordination**

- Epidemiology personnel identified for investigation
- Additional epidemiology personnel support requested (From other regions) Investigation activities coordinated with FBI

**Communication**

- Epidemiology investigation spokesperson identified
- Communication protocol established between epidemiologic investigation spokesperson and Public Information Officer (PIO)

**Epidemiologic Investigation**

- Hypothesis-generating interviews conducted
- Preliminary epidemiologic curve generated
- Case definition established

**A. Case finding**

- Telephone hotline established
- Telephone intake form distributed
- Case definition disseminated to potential reporting sources
  - Hospitals
  - Physicians
  - Laboratories
  - EMS
  - Coroner
  - Media

**B. Case interviews**

- Interviewers trained
- Uniform multi-jurisdictional outbreak investigation form(s) obtained

**C. Data Analysis**

- Uniform multi-jurisdictional database template for data entry obtained
- Epidemiologic curve generated
- Cases line-listed
- Case descriptive epidemiology completed
  - Age
  - Gender
  - Illness onset
  - Clinical profile
  - % Laboratory confirmed
  - Hospitalization rate
  - Case fatality rate
  - Case geographic distribution mapped (GIS mapping if available)
  - Analytic epidemiology completed
  - Disease risk factors identified
  - Mode of transmission identified
  - Source of transmission identified
  - Population at continued risk identified

**Contact Tracing**

- Contact tracing forms distributed
- Health education materials available
- Contact management triage algorithm reviewed with staff
- Treatment/ prophylaxis guidelines available
- Treatment/ prophylaxis distribution plan in place
- System in place for locating contacts
- Tracking system in place to monitor contacts' trends/ gaps

**Laboratory**

- Establish point of contact (POC) at appropriate Level A and/ or Level B public health laboratory to refer queries regarding specimen packaging, storage and shipping guidelines in a potential bioterrorist event [See Laboratory Section's Bioterrorism Plan]

**Public Health Recommendations**

- See Medical Response Section Bioterrorism Plan

**UNSPECIFIED NEUROLOGICAL SYNDROME**

**CASE INVESTIGATION FORM**

ID NUMBER: \_\_\_\_\_  
INTERVIEWER: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_  
DATE OF INTERVIEW: \_\_\_\_/\_\_\_\_/\_\_\_\_  
PERSON INTERVIEWED:  Patient  Other  
IF OTHER, NAME OF PERSON \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
DESCRIBE RELATIONSHIP \_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

DRIVER LICENCE OR SOCIAL SECURITY NUMBER (Circle one): \_\_\_\_\_

SEX:  Male  Female DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_

RACE:  White  Black  Asian  Other, specify \_\_\_\_\_  Unknown

ETHNICITY:  Hispanic  Non-Hispanic  Unknown

HOME PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK/OTHER PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_

HOME ADDRESS STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYED:  Yes  No  Unknown

BRIEF DESCRIPTION OF  
JOB: \_\_\_\_\_

SCHOOL/PLACE OF  
EMPLOYMENT: \_\_\_\_\_  
DEPARTMENT \_\_\_\_\_ FLOOR: \_\_\_\_\_ ROOM: \_\_\_\_\_  
WORK/SCHOOL ADDRESS: STREET: \_\_\_\_\_ CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ARE YOU A:  
LAB WORKER/TECHNICIAN:  Yes  No  Unknown  
TAXIDERMIST:  Yes  No  Unknown  
VETERINARIAN:  Yes  No  Unknown  
FARMER:  Yes  No  Unknown  
ABATTOIR:  Yes  No  Unknown  
BUTCHER:  Yes  No  Unknown  
OTHER FOOD PREPERATION:  Yes  No  Unknown



**SIGNS AND SYMPTOMS**

Fever  Yes  No  Unknown

If yes, Maximum temperature \_\_\_\_\_  °F

Antipyretics taken  Yes  No  Unknown

Headache  Yes  No  Unknown

Stiff neck  Yes  No  Unknown

Photophobia  Yes  No  Unknown

Fatigue  Yes  No  Unknown

Altered mental status  Yes  No  Unknown

Unconscious/unresponsive  Yes  No  Unknown

Seizures  Yes  No  Unknown

Sensory changes  Yes  No  Unknown

Muscle weakness  Yes  No  Unknown

If yes, specify:  Upper Extremities  Lower Extremities  Both  
 Unilateral  Bilateral

Pattern of progression:  Ascending  Descending  Unknown

Blurred or double vision  Yes  No  Unknown

Difficulty swallowing  Yes  No  Unknown

Difficulty speaking  Yes  No  Unknown

Dry mouth  Yes  No  Unknown

Excess salivation  Yes  No  Unknown

Sore throat  Yes  No  Unknown

Muscle pains  Yes  No  Unknown

Nausea  Yes  No  Unknown

Diarrhea  Yes  No  Unknown

Vomiting  Yes  No  Unknown

Shortness of breath  Yes  No  Unknown

Cough  Yes  No  Unknown

Rash  Yes  No  Unknown

If yes, describe: \_\_\_\_\_

Other abnormality: \_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY:**

Do you have a regular physician?  Yes  No  Unknown  
If yes, Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Are you allergic to any medications?  Yes  No  Unknown  
If yes, list: \_\_\_\_\_

Are you currently taking any medication:  Yes  No  Unknown  
If yes, list: \_\_\_\_\_

Have you had any wound or lesion in the past several months?  
 Yes  No  Unknown  
If yes, where: \_\_\_\_\_ Appearance: \_\_\_\_\_

Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pulmonary Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cardiac disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Other neurologic condition  Yes  No  Unknown  
If yes, describe: \_\_\_\_\_

Malignancy  Yes  No  Unknown  
If yes, specify type: \_\_\_\_\_

Currently on treatment:  Yes  No  Unknown

HIV infection  Yes  No  Unknown

Currently pregnant  Yes  No  Unknown

Other immunocompromising condition (e.g., renal failure, cirrhosis, chronic steroid use)  
 Yes  No  Unknown  
If yes, specify disease or drug therapy: \_\_\_\_\_

Other underlying condition(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescription medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**PHYSICAL EXAM:**

Admission Vital Signs:

Temp:\_\_\_\_ ( Oral / Rectal F / C ) Heart Rate:\_\_\_\_\_ Resp. Rate:\_\_\_\_\_ B/P:\_\_\_\_/\_\_\_\_

Neurologic examination:

Meningismus (neck stiffness): Present Absent Not Noted

Mental Status: Normal Abnormal Not Noted

If abnormal, level of consciousness:

- Lethargic
- Unconscious
- Other \_\_\_\_\_

Agitation: Present Absent Not Noted

Cranial nerve function: Normal Abnormal Not Noted

If abnormal, specify: \_\_\_\_\_

Motor Exam: Normal Abnormal Not Noted

Left Arm:  Absent  Decreased  Normal  increased

Right Arm:  Absent  Decreased  Normal  increased

Left Leg:  Absent  Decreased  Normal  increased

Right Leg:  Absent  Decreased  Normal  increased

Sensory exam: Normal Abnormal Not Noted

Respiratory status: Normal Abnormal Not Noted

If abnormal, describe: \_\_\_\_\_

Skin: Normal Abnormal Not Noted

If rash present, describe type and location: \_\_\_\_\_

DIAGNOSTIC STUDIES:

Test	Results of tests done on Admission ( ___/___/___ )	Abnormal test result at any time (specify date mm/dd/yyyy)
Hemoglobin (Hb)		( ___/___/___ )
Hematocrit (HCT)		( ___/___/___ )
Platelet (plt)		( ___/___/___ )
Test	Results of tests done on Admission ( ___/___/___ )	Abnormal test result at any time (specify date mm/dd/yyyy)
Total white blood cell (WBC)		( ___/___/___ )
WBC differential:		( ___/___/___ )
% granulocytes (PMNs)		( ___/___/___ )
% bands		( ___/___/___ )
% lymphocytes		( ___/___/___ )
Blood cultures:	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )
Botulinum toxin testing—serum:	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )
Botulinum toxin testing—stool:	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )

Test	Results of tests done on Admission ( ___/___/___ )	Abnormal test result at any time (specify date mm/dd/yy)
Lumbar puncture—cerebrospinal fluid (CSF) analysis: Gram stain (check all that apply)	<input type="checkbox"/> no organisms <input type="checkbox"/> gram positive cocci <input type="checkbox"/> gram negative cocci <input type="checkbox"/> gram positive rods <input type="checkbox"/> gram negative coccobacilli <input type="checkbox"/> gram negative rods <input type="checkbox"/> acid-fast bacilli <input type="checkbox"/> fungal forms <input type="checkbox"/> other _____	<input type="checkbox"/> no organisms <input type="checkbox"/> gram positive cocci <input type="checkbox"/> gram negative cocci <input type="checkbox"/> gram positive rods <input type="checkbox"/> gram negative coccobacilli <input type="checkbox"/> gram negative rods <input type="checkbox"/> acid-fast bacilli <input type="checkbox"/> fungal forms <input type="checkbox"/> other _____ ( ___/___/___ )
Lumbar puncture—CSF analysis: Bacterial culture	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )
Lumbar puncture—CSF analysis: Viral culture	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )
Lumbar puncture—CSF analysis: Other culture	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done	<input type="checkbox"/> positive (specify _____) <input type="checkbox"/> negative <input type="checkbox"/> pending <input type="checkbox"/> not done ( ___/___/___ )
Lumbar puncture—CSF analysis: Other test (e.g., herpes PCR)		( ___/___/___ )
Chest radiograph	<input type="checkbox"/> normal <input type="checkbox"/> unilateral, lobar/consolidation <input type="checkbox"/> bilateral, lobar/consolidation <input type="checkbox"/> interstitial infiltrates <input type="checkbox"/> widened mediastinum <input type="checkbox"/> pleural effusion <input type="checkbox"/> other _____	<input type="checkbox"/> normal <input type="checkbox"/> unilateral, lobar/consolidation <input type="checkbox"/> bilateral, lobar/consolidation <input type="checkbox"/> interstitial infiltrates <input type="checkbox"/> widened mediastinum <input type="checkbox"/> pleural effusion <input type="checkbox"/> other _____ ( ___/___/___ )
CT Scan of brain	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) _____ ) ? <input type="checkbox"/> not done	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) _____ ) ? <input type="checkbox"/> not done ( ___/___/___ )

Test	Results of tests done on Admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)
MRI Scan of brain	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) ? <input type="checkbox"/> not done	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) ? <input type="checkbox"/> not done ( ___ / ___ / ___ )
Tensilon test	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) ? <input type="checkbox"/> not done	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) ? <input type="checkbox"/> not done ( ___ / ___ / ___ )
Electromyogram (EMG)	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) ? <input type="checkbox"/> not done	<input type="checkbox"/> normal <input type="checkbox"/> abnormal (describe: _____) ? <input type="checkbox"/> not done ( ___ / ___ / ___ )
Other pertinent study results (e.g., toxin assays)		( ___ / ___ / ___ )
Other pertinent study results (e.g., toxin assays)		( ___ / ___ / ___ )

NEUROLOGY CONSULTED:  Yes  No  Unknown

Date of Exam: \_\_\_ / \_\_\_ / \_\_\_

Name of neurologist: Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Telephone or beeper number ( ) \_\_\_\_\_ - \_\_\_\_\_

INFECTIOUS DISEASE CONSULT:  Yes  No  Unknown

Date of Exam: \_\_\_ / \_\_\_ / \_\_\_

Name of ID physician: Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Telephone or beeper number ( ) \_\_\_\_\_ - \_\_\_\_\_

**HOSPITAL COURSE:**

A. antibiotics:  Yes  No  Unknown

If yes, check all that apply:

- Ampicillin
- Cefepime (Maxipime)
- Cefotaxime (Claforan)
- Ceftazidime (Fortaz, Tazicef, Tazidime)
- Ceftizoxime (Cefizox)
- Ceftriaxone (Rocephin)
- Chloramphenicol
- Gentamicin (Garamycin)
- Penicillin G
- Trimethaprim-sulfamethoxazole (Bactrim, Cotrim, TMP/SMX)
- Vancomycin (Vancocin)
- other \_\_\_\_\_

B. antivirals :  Yes  No  Unknown

If yes, check all that apply:

- Acyclovir (Zovirax)
- other \_\_\_\_\_

C. botulinum anti-toxin:  Yes  No  Unknown

D. Did patient require intensive care:  Yes  No  Unknown

If patient was admitted to Intensive Care Unit:

- a. Length of stay in ICU, in days: \_\_\_\_\_
- b. Was patient on mechanical ventilation:  Yes  No  Unknown

**WORKING OR DISCHARGE DIAGNOSIS(ES) :**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**OUTCOME:**

- Recovered/discharged
- Died
- Still in hospital:  improving ?  worsening ?

**ADDITIONAL COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Risk Exposure Questions**

The following questions pertain to the 2 week period prior to the onset of your illness/symptoms:

*Occupation (provide information for all jobs/ volunteer duties)*

1. Please briefly describe your job/ volunteer duties: \_\_\_\_\_

2. Does your job involve contact with the public? :  Yes  No

If "Yes", specify \_\_\_\_\_

3. Does anyone else at your workplace have similar symptoms?

Yes  No  Unknown

If "Yes", name and approximate date on onset (if known) \_\_\_\_\_

**Knowledge of Other Ill Persons**

4. Do you know of other people with similar symptoms? :  Yes  No  Unknown

(If Yes, please complete the following questions)

Name of ill Person	AGE	Sex	Address	Phone	Date of Onset	Relation To you	Did they seek Medical care? Where	Diagnosis

**Travel\***

\*Travel is defined as staying overnight (or longer) at somewhere other than the usual residence

8. Have you traveled anywhere in the last two weeks? :  Yes  No  Unknown

Dates of Travel: \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Method of Transportation for Travel: \_\_\_\_\_

Where Did You Stay? \_\_\_\_\_

Purpose of Travel? \_\_\_\_\_

Did You Do Any Sightseeing on your trip? :  Yes  No

If yes, specify: \_\_\_\_\_

Did Anyone Travel With You? :  Yes  No

If yes, specify: \_\_\_\_\_

Are they ill with similar symptoms? :  Yes  No  Unknown

If yes, specify: \_\_\_\_\_

**Public Functions/Venues (during 2 weeks prior to symptom onset)**

Category	Y/ N/ U	Description of Activity	Location of Activity	Date of Activity	Time of Activity (start, end)	Others ill? (Y/N/U)
9. Airports						
10. Beaches						
11. Bars/Clubs						
12. Campgrounds						
13. Carnivals/Circus						
14. Casinos						
15. Family Planning Clinics						
16. Government Office Building						
17. Gym/Workout Facilities						
18. Meetings or Conferences						
19. Movie Theater						
20. Museums						
21. Parks						
22. Parties (including Raves, Prom, etc)						
23. Performing Arts (ie Concert, Theater, Opera)						
24. Picnics						
25. Political Events						
26. Religious Gatherings						
27. Shopping Malls						
28. Sporting Event						
29. Street Festivals, Flea Markets, Parades						
30. Tourist Attractions (ie French Quarter, Aquarium)						

**Transportation**

Have you used the following types of transportation in the 2 weeks prior to onset?

31. Bus/Streetcar:  Yes  No  Unknown

Frequency of this type of transportation:  Daily  Weekly  Occasionally  Rarely

Bus Number: \_\_\_\_\_ Origin: \_\_\_\_\_

Any connections?  Yes  No (Specify: Location \_\_\_\_\_ Bus# \_\_\_\_\_)

Company Providing Transportation: \_\_\_\_\_ Destination: \_\_\_\_\_

32. Train:  Yes  No  Unknown

Frequency of this type of transportation:  Daily  Weekly  Occasionally  Rarely

Route Number: \_\_\_\_\_ Origin: \_\_\_\_\_

Any connections?  Yes  No (Specify: Location \_\_\_\_\_ Route # \_\_\_\_\_)

Company Providing Transportation: \_\_\_\_\_ Destination: \_\_\_\_\_

33. Airplane:  Yes  No  Unknown

Frequency of this type of transportation:  Daily  Weekly  Occasionally  Rarely

Flight Number: \_\_\_\_\_ Origin: \_\_\_\_\_

Any connections?  Yes  No (Specify: Location \_\_\_\_\_ Flight # \_\_\_\_\_)

Company Providing Transportation: \_\_\_\_\_ Destination: \_\_\_\_\_

34. Ship/Boat/Ferry:  Yes  No  Unknown

Frequency of this type of transportation:  Daily  Weekly  Occasionally  Rarely

Ferry Number: \_\_\_\_\_ Origin: \_\_\_\_\_

Any connections?  Yes  No (Specify: Location \_\_\_\_\_ Ferry # \_\_\_\_\_)

Company Providing Transportation: \_\_\_\_\_ Destination: \_\_\_\_\_

35. Van Pool/Shuttle:  Yes  No  Unknown

Frequency of this type of transportation:  Daily  Weekly  Occasionally  Rarely

Route Number: \_\_\_\_\_ Origin: \_\_\_\_\_

Any connections?  Yes  No (Specify: Location \_\_\_\_\_ Route # \_\_\_\_\_)

Company Providing Transportation: \_\_\_\_\_ Destination: \_\_\_\_\_

**Food & Beverage**

36. During the 2 weeks before your illness, did you eat at any of the following *food establishments or private gatherings with food or beverages*?

Food Establishment	Y/ N/ U	Name of Establishment	Location of Meal	Date of Meal	Time of Meal (start, end)	Food and Drink items consumed	Others ill? (Y/N/U)
Cafeteria at School, hospital, or other							
Casino or mall food court							
Grocery Store or Corner Store							
Concert, movie, or other entertainment							
Dinner party, birthday party or other celebration							
Gas station or convenience store							
Plane, boat, train, or other							
Picnic, Barbecue, Crawfish boil, or potluck							
Outdoor farmers market, festival, or swap meet							
Restaurant, fast-food, or deli							
Sporting event or snack bar							
Street vended food							
Other food establishment							
Other Private Gathering							

37. During the 2 weeks before your illness, did you consume any free *food samples* from:

- Grocery store Yes No Unknown  
 Race/competition Yes No Unknown  
 Public gathering? Yes No Unknown  
 Private gathering? Yes No Unknown

If "YES" for any in question #37, provide date, time, location and list of food items consumed:

Date/Time: \_\_\_\_\_

Location (Name and Address): \_\_\_\_\_

Food/drink consumed: \_\_\_\_\_

Others also ill?  Yes  No  Unknown

(explain): \_\_\_\_\_

38. During the 2 weeks before your illness, did you consume any of the following **products**?

Vitamins  Yes  No  Unknown

Specify (Include Brand Name): \_\_\_\_\_

Herbal remedies  Yes  No  Unknown

Specify (Include Brand Name): \_\_\_\_\_

Diet Aids  Yes  No  Unknown

Specify (Include Brand Name): \_\_\_\_\_

Nutritional Supplements  Yes  No  Unknown

Specify (Include Brand Name): \_\_\_\_\_

Other Ingested non-food  Yes  No  Unknown

Specify (Include Brand Name): \_\_\_\_\_

39. During the 2 weeks before your illness, did you consume any unpasteurized products (ie milk, cheese, fruit juices)?  Yes  No  Unknown

If yes, specify name of item: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Location (Name and Address): \_\_\_\_\_

Others also ill?:  Yes  No  Unknown

(explain): \_\_\_\_\_

40. During the 2 weeks before your illness, did you purchase food from any internet grocers?

Yes  No  Unknown

If yes, specify date / time of delivery: \_\_\_\_\_ Store/Site: \_\_\_\_\_

Items purchased: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

41. During the 2 weeks before your illness, did you purchase any mail order food?  Yes  No

Unknown

If yes, specify date/time of delivery: \_\_\_\_\_

Store purchased from: \_\_\_\_\_ Items

purchased: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

42. Please check the routine sources for drinking water (check all that apply):

- Community or Municipal
- Well (shared)
- Well (private family)
- Bottled water (Specify Brand: \_\_\_\_\_)
- Other (Specify: \_\_\_\_\_)

***Aerosolized water***

43. During the 2 weeks prior to illness, did you consume water from any of the following sources (check all that apply):

- Wells
- Lakes
- Streams
- Springs
- Ponds
- Creeks
- Rivers
- Sewage-contaminated water
- Street-vended beverages ( Made with water or ice and sold by street vendors)
- Ice prepared w/ unfiltered water (Made with water that is not from a municipal water supply or that is not bottled or boiled)
- Unpasteurized milk
- Other  
(Specify: \_\_\_\_\_)

If “YES” for any in question #43, provide date, time, location and type of water consumed:

Date/Time: \_\_\_\_\_

Location (Name and Address): \_\_\_\_\_

Type of water consumed: \_\_\_\_\_

Others also ill?:  Yes .  No  Unknown

(explain): \_\_\_\_\_

44. During the 2 weeks prior to illness, did you engage in any of the following recreational activities (check all that apply):

- Swimming in public pools (e.g., community, municipal, hotel, motel, club, etc)
- Swimming in kiddie/wading pools
- Swimming in sewage-contaminated water
- Swimming in fresh water, lakes, ponds, creeks, rivers, springs, sea, ocean, bay (please circle)
- Wave pools ? Water parks ? Waterslides ? Surfing
- Rafting ? Boating ? Hot tubs (non-private) ? Whirlpools (non-private)
- Jacuzzis (non-private) ? Other (Specify: \_\_\_\_\_)

If “YES” for any in question #44, provide date, time, location and type of activity:

Date/Time: \_\_\_\_\_

Location (Name and Address): \_\_\_\_\_

Type of water consumed: \_\_\_\_\_

Others also ill?:  Yes .  No  Unknown

(explain): \_\_\_\_\_

45. During the 2 weeks prior to illness, were you exposed to aerosolized water from any of the following non-private (i.e., used in hospitals, malls, etc) sources (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Air conditioning at public places | <input type="checkbox"/> Respiratory devices  |
| <input type="checkbox"/> Vaporizers                        | <input type="checkbox"/> Humidifiers          |
| <input type="checkbox"/> Misters                           | <input type="checkbox"/> Whirlpool spas       |
| <input type="checkbox"/> Hot tub                           | <input type="checkbox"/> Spa baths            |
| <input type="checkbox"/> Creek and ponds                   | <input type="checkbox"/> Decorative fountains |
| <input type="checkbox"/> Other (please explain) _____      |   |

If "YES" for any in question #45, provide date, time, and location of exposure to aerosolized water:

Date/Time: \_\_\_\_\_

Location (Name and Address): \_\_\_\_\_

Explanation of aerosolized water: \_\_\_\_\_

Others also ill: Yes . No Unknown

(explain): \_\_\_\_\_

**Recreation** (Activities that are not related to work)

46. In the past two weeks, did you participate in any outdoor activities?

- Yes . No Unknown

(If "yes", list all activities and provide locations)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

47. Did you participate in other indoor recreational activities (i.e. clubs, crafts, etc that did not occur in a private home)?

- Yes . No Unknown

(List all activities and provide location)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vectors**

48. Do you recall any insect or tick bites in the last 2 weeks?

Yes  No  Unknown

Date(s) of bite(s): \_\_\_\_\_

Bitten by:  Mosquito  Tick  Flea  Fly  Other:

Where were you when you were bitten? \_\_\_\_\_

49. Have you had any contact with wild or domestic animals, including pets?

Yes  No  Unknown

Type of Animal: \_\_\_\_\_

Explain nature of contact: \_\_\_\_\_

Is / was the animal ill recently:  Yes  No  Unknown

If yes please describe the animal's symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date / Time of contact: \_\_\_\_\_

Location of contact: \_\_\_\_\_

50. To your knowledge, have you been exposed to rodents/rodent droppings in the last 2 weeks?

Yes  No  Unknown

If yes, explain type of exposure: \_\_\_\_\_

Date/Time of exposure: \_\_\_\_\_

Location where exposure occurred: \_\_\_\_\_

