



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

Unspecified Gastrointestinal Syndrome

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EPIDEMIOLOGY

Although few pathogens identified as possible agents of bioterrorism will cause patients to present with a gastrointestinal disease there are many organisms that could be deployed against food and water supplies that would cause a gastrointestinal illness. Given the fact that most disease agents would be unknown in the event of an outbreak and the fact that so many organisms can cause gastrointestinal illnesses there is certainly a need to plan to respond to gastrointestinal diseases caused by unknown agents. The list of likely bioterrorism agents that could cause a respiratory type illness includes anthrax, and E. coli. Additionally there are many other enteric organisms of public health concern have the ability to cause syndromes involving the gastrointestinal system.

CLINICAL FEATURES

Signs and Symptoms: Clinical manifestations of the different diseases that might be considered would present with gastrointestinal involvement. The clinical features of any given disease that primarily affects the body's gastrointestinal tract are quite common and non-specific. 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 gastrointestinal 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 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

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

HOBBY:

- Do you work with fibers/wool/animal skin/or other animal product? Yes No Unknown
- Have you been camping in past two months? Yes No Unknown
- Have you stayed in cabins in the past two months? Yes No Unknown
- Have you been hunting? Yes No Unknown
- Have you skinned or dressed and animal? Yes No Unknown
- Have you had an animal stuffed or mounted? Yes No Unknown

HOW MANY PEOPLE RESIDE IN THE SAME HOUSEHOLD? _____

LIST NAME(S), AGE(S), AND RELATIONSHIPS (use additional pages if necessary):

	PERSON 1	PERSON 2	PERSON 3	PERSON 4	PERSON 5	PERSON 6
Name						
Age						
Relationship						

HOUSEHOLD PETS:

Does your household have any pets (indoor or outdoor)? Yes No Unknown

If so what type of pet: _____

Have any of the pets been ill or died recently? Yes No Unknown

If so describe: _____

CLINICAL INFORMATION

CHIEF COMPLAINT: _____

DATE OF ILLNESS ONSET: ____/____/____

Which was experienced first? Vomiting Diarrhea

Onset time: ____:____ AM PM

Currently experiencing vomiting or diarrhea? Yes No Unknown

Willing to provide a stool sample? Yes No Unknown

Date of last day of illness with vomiting or diarrhea: ____/____/____

Time of last episode of vomiting or diarrhea: ____:____ AM PM

Total number of days of diarrhea: ____ days

Briefly summarize History of Present Illness:

SIGNS AND SYMPTOMS

Nausea Yes No Unknown
Vomiting Yes No Unknown
Diarrhea Yes No Unknown

If yes, what is the maximum number of stools in a 24-hour period: _____

Bloody diarrhea Yes No Unknown
Abdominal pain and cramps Yes No Unknown
Gas Yes No Unknown
Loss of appetite Yes No Unknown
Fever Yes No Unknown

If yes, Maximum temperature _____ °F

Antipyretics taken Yes No Unknown
Chills Yes No Unknown
Muscle aches Yes No Unknown
Fatigue Yes No Unknown
Constipation Yes No Unknown
Weight loss Yes No Unknown

If yes, how many pounds have been lost: ____ lbs in ____ days

Other Symptom or 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: _____

Food allergies Yes No Unknown

If yes, describe: _____

Diabetes Yes No Unknown

Malignancy Yes No Unknown

If yes, specify type: _____

Currently in treatment Yes No Unknown

Cardiac disease Yes No Unknown

HIV infection Yes No Unknown

Other Immunocompromising condition (i.e. renal failure, cirrhosis, chronic steroid use)
 Yes No Unknown

If yes, specify disease or drug therapy: _____

Currently pregnant Yes No Unknown

Colitis/inflammatory bowel disease Yes No Unknown

Surgery to remove part of the stomach
or small intestines: Yes No Unknown

Other immunocompromising condition (e.g., renal failure, cirrhosis, chronic steroid use)

Yes No Unknown

Other underlying condition(s):

Prescription medications:

SOCIAL HISTORY:

Current alcohol abuse:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Past alcohol abuse:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Current injection drug use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Past injection drug use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Current smoker:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Former smoker:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other illicit drug use:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

If yes, specify: _____

HOSPITAL INFORMATION:

HOSPITALIZED: Yes No

NAME OF HOSPITAL: _____

DATE OF ADMISSION: ___/___/___ DATE OF DISCHARGE ___/___/___

ATTENDING PHYSICIAN: LAST NAME: _____ FIRST NAME: _____

Office Telephone: () ___ - ___ Pager: () ___ - ___ Fax: () ___ - ___

MEDICAL RECORD ABSTRACTION :

MEDICAL RECORD NUMBER: _____

WARD/ROOM NUMBER: _____

ADMISSION DIAGNOSIS(ES): 1) _____

2) _____

3) _____

PHYSICAL EXAM:

Admission Vital Signs:

Temp: ____ (Oral / Rectal F / C) Heart Rate: _____ Resp. Rate: _____ B/P: ____/____

Mental Status: Normal Abnormal Not Noted

If abnormal, describe: _____

Respiratory status: Normal spontaneous Respiratory distress Ventilatory support

If abnormal, check all that apply:

- Rales
- Stridor/wheezin
- Decreased or absent

Other (specify: _____)

Skin: Normal Abnormal Not Noted

If abnormal, check all that apply:

- Edema
- Chest wall edema
- Cyanosis
- Erythema
- Petechiae
- Sloughing/necrosis
- Purpura
- Rash

If rash present, describe type and location on body : _____

Other abnormal physical findings (describe): _____

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)		(___/___/___)
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 (___/___/___)
Stool 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 (___/___/___)
Fecal white blood cells	<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 (___/___/___)
Stool ova and parasite exam	<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)

Chest radiograph

- normal
- unilateral, lobar/consolidation
- bilateral, lobar/consolidation
- interstitial infiltrates
- widened mediastinum
- pleural effusion
- other _____

- normal
- unilateral, lobar/consolidation
- bilateral, lobar/consolidation
- interstitial infiltrates
- widened mediastinum
- pleural effusion
- other _____

(___ / ___ / ___)

Other pertinent study results

(___ / ___ / ___)

Other pertinent study results (e.g., toxin assays)

(___ / ___ / ___)

GASTERO-ENTEROLOGY 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:

<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Cefuroxime (Ceftin)
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Ciprofloxacin (Cipro)
<input type="checkbox"/> Ampicillin and sulbactam (Unasyn)	<input type="checkbox"/> Clindamycin (Cleocin)
<input type="checkbox"/> Augmentin (amoxicillin and clavulanate)	<input type="checkbox"/> Gentamicin (Garamycin)
<input type="checkbox"/> Cefotentan (Cefotan)	<input type="checkbox"/> Levofloxacin (Levaquin)
<input type="checkbox"/> Cefoxitin (Mefoxin)	<input type="checkbox"/> Metronidazole (Flagyl)
<input type="checkbox"/> Ceftazidime (Fortaz, Tazicef, Tazidime)	<input type="checkbox"/> Piperacillin and Tazobactam (Zosyn)
<input type="checkbox"/> Ceftizoxime (Cefizox)	<input type="checkbox"/> Ticarcillin and clavulanate (timentin)
<input type="checkbox"/> Ceftriaxone (Rocephin)	<input type="checkbox"/> Trimethaprim-sulfamethoxazole (Bactrim, Cotrim, TMP/SMX)

other _____

B. 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 ?

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
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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 (including Marches)						
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):

- Air conditioning at public places
- Respiratory devices
- Vaporizers
- Humidifiers
- Misters
- Whirlpool spas
- Hot tub
- Spa baths
- Creek and ponds
- Decorative fountains
- 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. Do you recall any insect or tick bites during these outdoor activities?

- Yes . No Unknown

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

48. 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

49. 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? _____

50. 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: _____

51. 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: _____