

**OPH-ID Epidemiology Section**

**CONFIDENTIAL**

**Suspected Bioterrorism 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

Other travelers to same places: if indicated follow up on these individuals

Name	Age	Sex	Address	Phone	Relationship	Onset date	Status

**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

**Vectors:** Bitten in past 2 weeks  Y  N - if Yes  Tick  Mosquito  Flea  Stable or horse fly

**Exposure to rodent droppings in past 2 weeks:**

Cleaned enclosed space inhabited by rodents  
 Cleaned dusty areas  Inhaled dust from building

**Activities** (Select relevant category to identify possible source of exposure, or possible secondary transmission sites))  
 during \_\_\_\_\_ days prior to disease (adjust to cover incubation period of suspected disease)

	Description	Location	Date	Comment
Airport, public transport hall				
Bar, club				
Beach				
Bus station, railway station				
Campground				
Carnival, circus				
Casino				
Clinic, medical care				
Festival				
Gym workout				
Meeting, conference				
Movie theater				
Museum				
Office building				
Park				
Party, prom, rave				
Performing arts				
Picnics				
Political rally				
Religious gathering				
Shopping mall				
School				
Sports event				
Street fair, flea market				
Tourist attraction: Zoo, aquarium				
<b>Transportation</b> (Select relevant category to identify possible source of exposure, or possible secondary transmission during _____ days prior to disease (adjust to cover incubation period of suspected disease))				
	Route: from ... to	Schedule /Time	Company	Comment
Airplane				
Boat, ferry				
Bus				
Street car				
Train				
Van pool				

**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

**List food establishments patronized during past month**

(This section is useful if foodborne transmission is suspected without definite knowledge of where exposure may

- 1-Restaurant, fast food, deli; 2-Cafeteria at school, work; 3-Grocery store; 4-Plane, boat, train;
- 5-Movie, concert, other entertainment; 6-Convenience store, gas station; 7-Snack bar; 8-Sporting event;
- 9-Street vendor; 10-Beach, park, outdoor event; 11-Dinner party, pot luck, barbecue;
- 12-Party, office, birthday party, celebration; 13-Other private gathering; 14- Catered food establishment,
- 15-Other

Name	Type	Date	Time	Food consumed

**Food purchase by mail order:**

**Food purchase by internet:**

**Routine source of drinking water:** (if waterborne pathogens are suspected)

Community water Private Well Bottled water brand

Other

**Contact with water:**

Well Stream Spring Pond Creek River Sewage  Other

**Exposure to aerosolized water:**

Air conditioning at public places Respiratory device Vaporizer

Humidifier Mister Whirlpool spa Hot tub  Spa bath Creek and pond Decorative fountain

If Yes describe

**Recreational water activities:**

Public pool Wading pool Water park Waterslide Rafting Boating

Jacuzzi Hot tub Whirlpool Other

If Yes describe

Consumption of	Y	N	Name, where purchased
Vitamin			
Herbal remedies			
Diet Aids			
Nutritional supplements			
Other			

<b>Medical History</b>					
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: →					
<b>Social history</b>					
Current alcohol abuse	Y N	Past alcohol abuse	Y N		→
Current injection drug abuse	Y N	Past injection drug abuse	Y N		→
Current smoker	Y N	Past smoker	Y N		→
Other current drug abuse	Y N	Past current drug abuse	Y N		→
<b>Onset: Symptoms</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Date symptoms started _____ Time _____					
<b>Signs and Symptoms</b> Circle best answer	<b>Onset</b>	<b>Signs and Symptoms</b> Circle best answer	<b>Onset</b>	<b>Describe</b>	
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

<b>Hospitalization</b> <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							
<b>Knowledge of other ill persons</b>							
Name	Age	Sex	Address	Phone	Relationship	Onset date	Status