

## OHIO CASE INVESTIGATION FORM CAMPYLOBACTERIOSIS

Please fill this form out either electronically or by hand. Please enter the data into ODRS where fields exist. Please upload the completed questionnaire to the Administration module of ODRS or fax it to (614) 564-2456.

Patient Name: \_\_\_\_\_ ODRS #: \_\_\_\_\_

Phone: \_\_\_\_\_

Local Health Department: \_\_\_\_\_

### INTERVIEW INFORMATION:

Date of first attempt to contact patient: \_\_\_\_\_ Patient interviewed: ☐ Yes ☐ No

Reason not interviewed: ☐ Lost to follow up ☐ Refused ☐ Time lag too long

☐ Other: \_\_\_\_\_

Date of initial interview: \_\_\_\_\_ Interviewer Agency: \_\_\_\_\_

Name of interviewer: \_\_\_\_\_ Interviewer phone: \_\_\_\_\_

Respondent's relationship: ☐ Self ☐ Mother ☐ Father  
☐ Foster parent ☐ Adoptive parent ☐ Guardian  
☐ Emergency contact ☐ Grandparent ☐ Extended family  
☐ Sibling ☐ Spouse  
☐ Other: \_\_\_\_\_

Name of respondent (if not self): \_\_\_\_\_

Was a complete exposure history\* obtained: ☐ Yes ☐ No ☐ Partial ☐ Unknown

\* Complete exposure history: to include an interview (of any format) that assesses exposures prior to illness via an open-ended exposure history or via a list of potential exposures. The key factor to be considered a complete exposure history is an interview that goes beyond assessment of high-risk settings and prevention education to ascertain food consumption or preference and other exposure data.

### DISEASE BEING INVESTIGATED:

☐ Campylobacteriosis

Exposure period: 1-10 days

**CASE INFORMATION:**

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex assigned at birth: ☐ Female ☐ MaleCurrent sex: ☐ Female ☐ Male ☐ Transgender female ☐ Transgender maleRace: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native☐ Hawaiian Native/Pacific Islander ☐ Unknown ☐ Other: \_\_\_\_\_Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Name of facility/work place: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Sensitive occupations	Yes	No	Unknown
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Direct patient care provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Child care provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Food handler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Transmission settings	Yes	No	Unknown
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Works at a day care or preschool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Attends a day care or preschool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Works at a school, college, or university	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Attends a school, college, or university	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Resides in a long-term care/assisted living facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Incarcerated in a correctional facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If YES to sensitive occupations or transmission settings, please provide more detail:

1. Name of facility/work place: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Duties/Activities: \_\_\_\_\_

2. Name of facility/work place: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Duties/Activities: \_\_\_\_\_

**CLINICAL INFORMATION:**Symptomatic: ☐ Yes ☐ No ☐ Unknown

Symptoms: ☐ Diarrhea      Date diarrhea started: \_\_\_\_\_  
☐ Bloody stool      ☐ Nausea      ☐ Fatigue  
☐ Fever      ☐ Abdominal cramps      ☐ UTI symptoms  
☐ Chills      ☐ Headache      ☐ Other: \_\_\_\_\_  
☐ Vomiting      ☐ Muscle aches

Illness onset date: \_\_\_\_\_ Illness end date: \_\_\_\_\_ Still ill: ☐ Yes ☐ No

Length of symptoms: \_\_\_\_\_ Days

Hospitalized: ☐ Yes ☐ No ☐ Unknown      Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_History of a condition that could cause chronic diarrhea or GI issues: ☐ Yes ☐ No ☐ Unknown

Specify: \_\_\_\_\_

History of an immunocompromising condition within 6 months prior to onset: ☐ Yes ☐ No ☐ Unknown

Specify \_\_\_\_\_

Antibiotics or other treatment prescribed for illness: ☐ Yes ☐ No ☐ Unknown

Name: \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Took antibiotics within 30 days prior to onset: ☐ Yes ☐ No ☐ Unknown

Name: \_\_\_\_\_

Took probiotics within 30 days prior to onset: ☐ Yes ☐ No ☐ Unknown

Name: \_\_\_\_\_

Took antacids within 30 days prior to onset: ☐ Yes ☐ No ☐ Unknown

Name: \_\_\_\_\_

**FOOD HISTORY:**

Drinking water source(s) consumed during exposure period:

☐ Municipal ☐ Well ☐ Bottled (personal-sized container) ☐ Bottled (multi-user tank) ☐ Spring  
☐ Unknown ☐ Other: \_\_\_\_\_

Sources of food prepared at home during exposure period:

<input type="checkbox"/> Grocery store, supermarket	<input type="checkbox"/> Health food store, co-op
<input type="checkbox"/> Warehouse store	<input type="checkbox"/> Fish/meat specialty shop
<input type="checkbox"/> Ethnic specialty market	<input type="checkbox"/> Live animal market, custom slaughter facility
<input type="checkbox"/> Meal delivery service	<input type="checkbox"/> Farmer's market, roadside stand
<input type="checkbox"/> Grocery delivery service	<input type="checkbox"/> Other: _____

Please list grocery stores, markets, etc. where food was purchased for home consumption:

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date(s) purchased: \_\_\_\_\_  
Use a shopper card: ☐ Yes ☐ No ☐ Unknown  
Permission to obtain shopper card records: ☐ Yes ☐ No  
Shopper card number: \_\_\_\_\_ or Phone number linked to card: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date(s) purchased: \_\_\_\_\_  
Use a shopper card: ☐ Yes ☐ No ☐ Unknown  
Permission to obtain shopper card records: ☐ Yes ☐ No  
Shopper card number: \_\_\_\_\_ or Phone number linked to card: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date(s) purchased: \_\_\_\_\_  
Use a shopper card: ☐ Yes ☐ No ☐ Unknown  
Permission to obtain shopper card records: ☐ Yes ☐ No  
Shopper card number: \_\_\_\_\_ or Phone number linked to card: \_\_\_\_\_
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date(s) purchased: \_\_\_\_\_  
Use a shopper card: ☐ Yes ☐ No ☐ Unknown  
Permission to obtain shopper card records: ☐ Yes ☐ No  
Shopper card number: \_\_\_\_\_ or Phone number linked to card: \_\_\_\_\_
5. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date(s) purchased: \_\_\_\_\_  
Use a shopper card: ☐ Yes ☐ No ☐ Unknown  
Permission to obtain shopper card records: ☐ Yes ☐ No  
Shopper card number: \_\_\_\_\_ or Phone number linked to card: \_\_\_\_\_
6. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date(s) purchased: \_\_\_\_\_  
Use a shopper card: ☐ Yes ☐ No ☐ Unknown  
Permission to obtain shopper card records: ☐ Yes ☐ No  
Shopper card number: \_\_\_\_\_ or Phone number linked to card: \_\_\_\_\_

Sources of food prepared outside the home during exposure period:

- |   |   |
|---|---|
| <input type="checkbox"/> Fast food                            | <input type="checkbox"/> Steakhouse, grill                                  |
| <input type="checkbox"/> Fast casual                          | <input type="checkbox"/> Diner, neighborhood cafe                           |
| <input type="checkbox"/> Sandwich shop, deli                  | <input type="checkbox"/> Breakfast, brunch                                  |
| <input type="checkbox"/> Mexican, other Hispanic/Latino-style | <input type="checkbox"/> Buffet   |
| <input type="checkbox"/> Italian                              | <input type="checkbox"/> School, hospital, senior center, other institution |
| <input type="checkbox"/> Seafood                              | <input type="checkbox"/> Catered event: _____                               |
| <input type="checkbox"/> Jamaican, Cuban, Caribbean           | <input type="checkbox"/> Food truck, food stall/stand                       |
| <input type="checkbox"/> Asian: Chinese, Indian, Japanese     | <input type="checkbox"/> Take-out from restaurant/restaurant delivery       |
| <input type="checkbox"/> Middle Eastern, Arabic, African      | <input type="checkbox"/> Ready-to-eat food from grocery store, deli         |
| <input type="checkbox"/> Vegetarian, Vegan                    | <input type="checkbox"/> Salad bar at grocery store/restaurant              |
| <input type="checkbox"/> Barbecue, home-style                 | <input type="checkbox"/> Other: _____                                       |

Please list restaurants, delis, etc. where food was purchased for consumption outside the home:

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date(s) purchased: \_\_\_\_\_ Time(s) purchased: \_\_\_\_\_  
Meal description: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date(s) purchased: \_\_\_\_\_ Time(s) purchased: \_\_\_\_\_  
Meal description: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date(s) purchased: \_\_\_\_\_ Time(s) purchased: \_\_\_\_\_  
Meal description: \_\_\_\_\_
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date(s) purchased: \_\_\_\_\_ Time(s) purchased: \_\_\_\_\_  
Meal description: \_\_\_\_\_
5. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date(s) purchased: \_\_\_\_\_ Time(s) purchased: \_\_\_\_\_  
Meal description: \_\_\_\_\_
6. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date(s) purchased: \_\_\_\_\_ Time(s) purchased: \_\_\_\_\_  
Meal description: \_\_\_\_\_

Attend/eat food from any group meals (e.g., weddings, banquets, pot lucks): ☐ Yes ☐ No ☐ Unknown

Please list group events where food was consumed:

1. Event: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Time of event: \_\_\_\_\_  
Caterer: \_\_\_\_\_  
Meal description: \_\_\_\_\_  
Others ill: ☐ Yes ☐ No ☐ Unknown Describe: \_\_\_\_\_
2. Event: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Time of event: \_\_\_\_\_  
Caterer: \_\_\_\_\_  
Meal description: \_\_\_\_\_  
Others ill: ☐ Yes ☐ No ☐ Unknown Describe: \_\_\_\_\_
3. Event: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date: \_\_\_\_\_ Time of event: \_\_\_\_\_  
Caterer: \_\_\_\_\_  
Meal description: \_\_\_\_\_  
Others ill: ☐ Yes ☐ No ☐ Unknown Describe: \_\_\_\_\_

Food allergies, special diets, vitamins, supplements:

Yes	Maybe	No	Don't know	Food preferences
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Selects organic foods when shopping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoids or never eats foods due to diet restrictions/preference Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Follows special or restricted diet Diet: <input type="checkbox"/> Kosher <input type="checkbox"/> Halal <input type="checkbox"/> Raw foods <input type="checkbox"/> Low carb <input type="checkbox"/> Paleo (high protein, low carb) <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Dairy-free <input type="checkbox"/> Gluten-free <input type="checkbox"/> Weight loss/low fat <input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Takes vitamins, nutritional supplements, herbal supplements Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Powdered nutritional supplements Product(s): <input type="checkbox"/> Protein powder <input type="checkbox"/> Meal replacement powder <input type="checkbox"/> Vitamin boosters <input type="checkbox"/> Power greens <input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keeps a food diary/log or posts meals to social media Please review/refer to this during interview

High risk food handling by anyone at home during exposure period:

Yes	Maybe	No	Don't know	High risk food handling by anyone at home
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raw poultry: <input type="checkbox"/> Chicken <input type="checkbox"/> Turkey <input type="checkbox"/> Other: _____

For infants < 1 year of age (skip rest of food questions):

Yes	Maybe	No	Don't know	Infant diet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breastfed, specify: <input type="checkbox"/> Exclusive <input type="checkbox"/> Supplemented
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formula Brand: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rice cereal, baby oatmeal Brand(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Baby food Brand(s): _____ Flavors: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Table food Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Juice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Milk: <input type="checkbox"/> Pasteurized <input type="checkbox"/> Unpasteurized Type: <input type="checkbox"/> Cow <input type="checkbox"/> Soy <input type="checkbox"/> Almond <input type="checkbox"/> Coconut <input type="checkbox"/> Goat <input type="checkbox"/> Camel <input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins, supplements Specify: _____

Food consumed during exposure period:

Yes	Maybe	No	Don't know	Food consumption
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Undercooked/raw: <input type="checkbox"/> Yes <input type="checkbox"/> Maybe <input type="checkbox"/> No <input type="checkbox"/> Unknown Type(s) consumed: <input type="checkbox"/> Whole <input type="checkbox"/> Rotisserie <input type="checkbox"/> Breast <input type="checkbox"/> Thigh <input type="checkbox"/> Wing <input type="checkbox"/> Leg/drumstick <input type="checkbox"/> Liver <input type="checkbox"/> Ground <input type="checkbox"/> Breaded (nuggets, tenders, patties) <input type="checkbox"/> Stuffed (cordon bleu, Kiev) <input type="checkbox"/> Other: _____ Purchased: <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> N/A Brand: _____ Prepared: <input type="checkbox"/> At home <input type="checkbox"/> Away from home <input type="checkbox"/> Unknown Place(s) of purchase: _____ Date(s) consumed: _____





**ANIMAL EXPOSURES:**

Settings where direct or indirect contact with animals occurred during exposure period:

Yes	Maybe	No	Don't know	Animal contact settings during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with animals on your property
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with animals at another household or location
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Handle pet food, treats, or chews
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with animal droppings or feces
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit a business or place where animals/birds were present
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit or work at a petting zoo
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit, work at, or live on a farm with livestock
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit or work at an agricultural farm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit or work at an agricultural feed store
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit or work at a pet store, swap meet, or place with animals/birds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visit a fair, 4-H event, or similar event where animals were present
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attend a school event, birthday party, other event with animals/pets

Animals such as pets, livestock, and wild animals encountered during exposure period:

Yes	Maybe	No	Don't know	Animal exposures during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dog or puppy Number of animals: _____ Approximate age: _____ Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____ Fed: <input type="checkbox"/> Dry pet food <input type="checkbox"/> Wet pet food <input type="checkbox"/> Raw pet food <input type="checkbox"/> Treats <input type="checkbox"/> Other: _____ Brands, flavors of pet food/treats: _____ Date purchased: _____ Place purchased: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cat or kitten Number of animals: _____ Approximate age: _____ Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____ Fed: <input type="checkbox"/> Dry pet food <input type="checkbox"/> Wet pet food <input type="checkbox"/> Raw pet food <input type="checkbox"/> Treats <input type="checkbox"/> Other: _____ Brands, flavors of pet food/treats: _____ Date purchased: _____ Place purchased: _____

Yes	Maybe	No	Don't know	Animal exposures during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Baby chick, duckling, or other baby poultry</p> <p>Type: <input type="checkbox"/> Chicks <input type="checkbox"/> Ducklings <input type="checkbox"/> Goslings <input type="checkbox"/> Other: _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store</p> <p><input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo</p> <p><input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Other: _____</p> <p>Date purchased: _____ Place purchased: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Live chicken, turkey, or other adult poultry</p> <p>Type: <input type="checkbox"/> Chickens <input type="checkbox"/> Ducks <input type="checkbox"/> Geese <input type="checkbox"/> Other: _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store</p> <p><input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo</p> <p><input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Other: _____</p> <p>Date purchased: _____ Place purchased: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Turtle, tortoise</p> <p>Type: <input type="checkbox"/> Red-eared slider <input type="checkbox"/> Yellow-bellied <input type="checkbox"/> Box</p> <p><input type="checkbox"/> Painted <input type="checkbox"/> Other: _____</p> <p>Shell size of animal(s): <input type="checkbox"/> 1-2 inches <input type="checkbox"/> 2-3 inches</p> <p><input type="checkbox"/> 3-4 inches <input type="checkbox"/> &gt; 4 inches <input type="checkbox"/> Unknown</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store</p> <p><input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo</p> <p><input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Crickets <input type="checkbox"/> Mealworms</p> <p><input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> Cooked meats <input type="checkbox"/> Live rodents</p> <p><input type="checkbox"/> Frozen rodents <input type="checkbox"/> Freshly dead rodents</p> <p><input type="checkbox"/> Other: _____</p> <p>Brands, flavors of pet food/treats: _____</p> <p>Date purchased: _____ Place purchased: _____</p>

Yes	Maybe	No	Don't know	Animal exposures during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snake (specify type): _____ Number of animals: _____ Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____ Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Crickets <input type="checkbox"/> Mealworms <input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> Cooked meats <input type="checkbox"/> Live rodents <input type="checkbox"/> Frozen rodents <input type="checkbox"/> Freshly dead rodents <input type="checkbox"/> Other: _____ Brands, flavors of pet food/treats: _____ Date purchased: _____ Place purchased: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other reptile Type: <input type="checkbox"/> Bearded dragon <input type="checkbox"/> Gecko <input type="checkbox"/> Other: _____ Number of animals: _____ Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____ Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Crickets <input type="checkbox"/> Mealworms <input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> Cooked meats <input type="checkbox"/> Live rodents <input type="checkbox"/> Frozen rodents <input type="checkbox"/> Freshly dead rodents <input type="checkbox"/> Other: _____ Brands, flavors of pet food/treats: _____ Date purchased: _____ Place purchased: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amphibian Type: <input type="checkbox"/> Frog <input type="checkbox"/> Toad <input type="checkbox"/> Salamander <input type="checkbox"/> Other: _____ Number of animals: _____ Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____ Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Crickets <input type="checkbox"/> Mealworms <input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> Cooked meats <input type="checkbox"/> Other: _____ Brands, flavors of pet food/treats: _____ Date purchased: _____ Place purchased: _____

Yes	Maybe	No	Don't know	Animal exposures during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Water pet in an aquarium</p> <p>Type: <input type="checkbox"/> Fish <input type="checkbox"/> Aquatic frog <input type="checkbox"/> Snail <input type="checkbox"/> Other: _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store  <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo  <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Commercial food <input type="checkbox"/> Crickets <input type="checkbox"/> Mealworms  <input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> Cooked meats <input type="checkbox"/> Other: _____</p> <p>Brands, flavors of pet food/treats: _____</p> <p>Date purchased: _____ Place purchased: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Pet rodent (hamster, gerbil, mouse)</p> <p>Type: <input type="checkbox"/> Rat <input type="checkbox"/> Mouse <input type="checkbox"/> Gerbil <input type="checkbox"/> Hamster  <input type="checkbox"/> Other: _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store  <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo  <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Dry pet food <input type="checkbox"/> Wet pet food <input type="checkbox"/> Raw pet food  <input type="checkbox"/> Treats <input type="checkbox"/> Other: _____</p> <p>Brands, flavors of pet food/treats: _____</p> <p>Date purchased: _____ Place purchased: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Pocket or exotic pet (rabbit, ferret, hedgehog)</p> <p>Type: <input type="checkbox"/> Ferret <input type="checkbox"/> Hedgehog <input type="checkbox"/> Rabbit <input type="checkbox"/> Guinea pig  <input type="checkbox"/> Other: _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store  <input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo  <input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Dry pet food <input type="checkbox"/> Wet pet food <input type="checkbox"/> Raw pet food  <input type="checkbox"/> Treats <input type="checkbox"/> Other: _____</p> <p>Brands, flavors of pet food/treats: _____</p> <p>Date purchased: _____ Place purchased: _____</p>

Yes	Maybe	No	Don't know	Animal exposures during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Livestock</b></p> <p>Type: <input type="checkbox"/> Cattle <input type="checkbox"/> Sheep <input type="checkbox"/> Goats <input type="checkbox"/> Pigs <input type="checkbox"/> Horses</p> <p><input type="checkbox"/> Other: _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store</p> <p><input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo</p> <p><input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Grass/hay <input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> Pellets <input type="checkbox"/> Meal</p> <p><input type="checkbox"/> Liquid <input type="checkbox"/> Other: _____</p> <p>Brands, types, details of feed: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Wild animal (specify):</b> _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store</p> <p><input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo</p> <p><input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Other (specify):</b> _____</p> <p>Number of animals: _____</p> <p>Any animal(s) ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Location of animal(s): <input type="checkbox"/> Home <input type="checkbox"/> Other's home <input type="checkbox"/> Pet store</p> <p><input type="checkbox"/> Feed store <input type="checkbox"/> School <input type="checkbox"/> Farm <input type="checkbox"/> Fair <input type="checkbox"/> Petting zoo</p> <p><input type="checkbox"/> Zoo <input type="checkbox"/> Swap meet/trade show <input type="checkbox"/> Other: _____</p> <p>Fed: <input type="checkbox"/> Dry pet food <input type="checkbox"/> Wet pet food <input type="checkbox"/> Raw pet food</p> <p><input type="checkbox"/> Treats <input type="checkbox"/> Other: _____</p> <p>Brands, flavors of pet food/treats: _____</p>

Notes on animal exposures:

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## TRAVEL AND ACTIVITIES:

Yes	Maybe	No	Don't know	Activities during exposure period
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attended a wedding, religious event, sporting event, picnic, school event, party, fair, festival, or other group event Type(s): <input type="checkbox"/> Wedding <input type="checkbox"/> Religious event <input type="checkbox"/> Sporting event <input type="checkbox"/> School event <input type="checkbox"/> Picnic <input type="checkbox"/> Party <input type="checkbox"/> Fair <input type="checkbox"/> Festival
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Went camping, hiking, hunting, or fishing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposed to recreational water (specify name/location below) Water: <input type="checkbox"/> Pool <input type="checkbox"/> Lake <input type="checkbox"/> Ocean <input type="checkbox"/> River <input type="checkbox"/> Hot tub/spa <input type="checkbox"/> Waterpark, specify ride/pool: _____ <input type="checkbox"/> Splash/spray pad <input type="checkbox"/> Other: _____ Type: <input type="checkbox"/> Public <input type="checkbox"/> Private Treated (e.g., chlorinated): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Traveled outside the United States
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Traveled outside of Ohio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Traveled within Ohio

If YES to any travel or activity questions, please fill in the details below:

- Name/Place: \_\_\_\_\_ Date from: \_\_\_\_\_ Date to: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Purpose: \_\_\_\_\_
- Name/Place: \_\_\_\_\_ Date from: \_\_\_\_\_ Date to: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Purpose: \_\_\_\_\_
- Name/Place: \_\_\_\_\_ Date from: \_\_\_\_\_ Date to: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Purpose: \_\_\_\_\_
- Name/Place: \_\_\_\_\_ Date from: \_\_\_\_\_ Date to: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Purpose: \_\_\_\_\_

Notes on travel and activities:

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**CONTACTS:**

Close contact with symptomatic person: ☐ Yes ☐ Maybe ☐ No ☐ Don't know

When was close contact ill: ☐ < 24 hours before case ☐  $\geq$  24 hours before case ☐ Unknown

Was close contact diapered: ☐ Yes ☐ No ☐ Unknown

Household, sexual, and other contacts' information:

	Name	Age	Sex	Relationship	Occupation/ School	III?	Onset Date
1.							
2.							
3.							
4.							
5.							

Anything else I have not asked you that you think may have caused your illness?

[illegible]