Attachment 6

10-day Post-exposure Questionnaire

Form Approved
OMB No. 0920-0527
Exp. Date

TELEPHONE INTERVIEW 10-14 DAYS FOLLOWING INITIAL INTERVIEW

Hello, this is _____ calling from (name of institution). May I speak with (Name of Contact Person from initial interview)?

About ___ days ago we spoke with you at (name of recreational area) and asked if you (your child/children) had been in the water on that day. We told you we'd be calling back to ask about your (your child/children) health. Is this a good time to talk?

I'll be reading a list of symptoms or health problems and want to know if you or anyone else in the family who was in the water that day has experienced them. If you've had any of the symptoms, I'll also ask about when they started and ended and if you've taken any medicine or seen a doctor about them.

Interviewer Initials:_____

Date:_____

Since your visit to (Recreational area), have you experienced any of the following symptoms or problems?

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
First I have a list of some general health symptoms.			
Fever Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Chills Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Headache Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Sore throat Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Ear ache Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Discharge or fluid running from ear Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Abdominal pain Y N DK	DK R ____/____/____	DK R ____/____/____	Y N DK

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
R	DD MM YY	DD MM YY	R
Nausea Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Vomiting Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Diarrhea Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Diarrhea with blood Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Other (specify)_____ Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Now, I have a few questions about eye symptoms			
Blurred Vision Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Irritation or pain Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Redness or discharge from eyes Y	DK R	DK R	Y

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
N DK R	____/____/____ DD MM YY	____/____/____ DD MM YY	N DK R
Conjunctivitis Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Other eye problems (specify)_____ Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R

Now I have a few questions about breathing-related symptoms

Cough or choke Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Shortness of breath Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Nasal congestion or runny nose Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Throat irritation Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Other (specify) _____ Y N DK	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
R			

Thank you. Now, I have some questions about problems you might have with your nerves

Agitation Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Confusion Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Dizziness Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Lethargy Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Loss of consciousness Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Weakness Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Seizures Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Numbness			

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Tremor Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R

Great. Now, just a few questions about skin problems.

Itchy skin Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Red skin Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Hives or welts Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Skin irritation/pain Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Rash (describe) _____ Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Infected cuts or scrapes			

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Other (specify) _____ Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R

Thank you, that's all. We appreciate you being a part of the study.