



Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212
Los Angeles, CA 90012
213-240-7941 (phone), 213-482-4856 (facsimile)
publichealth.lacounty.gov/acd/

VCMR ID: _____ County: _____ State assigned ID: _____

Patient interview is best; if patient is paralyzed, but is able to communicate, please obtain information directly from patient as possible, with supplementation by family/friends. If the patient is unable to be interviewed, please obtain history from as many different sources as possible, including household contacts (e.g. spouse, parents, siblings) and friends. Contact tracing table is available on page 8. Ask to review social media contacts/ threads (e.g. Facebook). It is critical to fill in every aspect of the days leading up to onset! Have a calendar handy and note any major holidays or events as reference.

Section 1: INTERVIEW INFORMATION (Questions 1-2 to be completed by interviewer prior to questionnaire administration)

- Interviewer Name: _____ Contact phone number: (____) _____ - _____
Agency or Organization: _____
- Respondent was: Self Parent Spouse Other: _____
a. If patient was interviewed, responses were: Verbal Written Hand squeeze Other: _____
- Interview Date(s) (MM/DD/YYYY): Int #1: ___/___/____ Int #2: ___/___/____ Int #3: ___/___/____
- Interview Language: English Spanish Other: _____

Section 2: DEMOGRAPHIC DATA (Questions 1-3 to be completed by interviewer prior to questionnaire administration)

- Patient name (Last, First): _____
- Age: _____ Years
- Sex: Male Female Unknown
- Ethnicity (check one): Hispanic/Latino Non-Hispanic/Non-Latino
- Race: White Black/African American American Indian/Alaska Native Asian
 Native Hawaiian/Other Pacific Islander Other (specify): _____ Unknown

Section 3: CLINICAL INFORMATION (For all dates below, use MM/DD/YYYY format)

- Onset date of neurological symptoms: ___/___/____ Unknown
- Hospital name: _____ Date of admission: ___/___/____ Not hospitalized
- Number of days in ICU: _____ No ICU stay
- Number of days intubated: _____ No intubation
- Date of discharge: ___/___/____ Not discharged as of: ___/___/____
- Disposition: Home Rehabilitation facility Deceased Unknown

Comments: _____

Section 4: MEDICAL HISTORY, TRAUMA, AND PROCEDURES

| Yes | No | UNK | Does the patient have: |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Underlying medical problems? a. Describe: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. A history of surgery to the GI tract (e.g., bowel resection, gastric bypass)? a. Describe: _____ <input type="checkbox"/> Unk |
| Yes | No | UNK | In the <u>one month</u> prior to illness onset, did the patient: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Sustain any wounds or injuries (e.g. fractures, falls, etc)? a. Describe: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Receive any pharmacologic botulism toxin (such as Botox, Myobloc) for cosmetic or therapeutic reasons? a. Describe: _____ <input type="checkbox"/> Unk b. Date of most recent use: ___/___/____ <input type="checkbox"/> Unk c. Number of units: _____ <input type="checkbox"/> Unk |

Section 4: MEDICAL HISTORY, TRAUMA, AND PROCEDURES (CONTINUED)

| Yes | No | UNK | In the one month prior to illness onset, did the patient: |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Have any dental procedures, such as a root canal? a. Describe: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Have any surgical procedures, either elective or emergent, such as a c-section, gallbladder removal, etc.? a. Describe: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Get tattoos or piercings? a. Describe: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Does the patient have any food allergies or dietary restrictions? a. Describe: _____ <input type="checkbox"/> Unk |

Comments: _____

Section 5: DRUG AND MEDICATION USE

| Yes | Maybe | No | Don't Know | In the one week prior to illness onset, did the patient: |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Take any prescription medications? a. Name of medication(s): _____ <input type="checkbox"/> Unk b. Route (oral, injection, etc) _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Consume edible marijuana? a. What form? (cookies, brownies, gummies etc) _____ <input type="checkbox"/> Unk b. Location purchased/ obtained: _____ <input type="checkbox"/> Unk c. Packaging/ details: _____ <input type="checkbox"/> Unk d. When consumed: _____ <input type="checkbox"/> Unk e. Other details: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Use any heroin? a. <input type="checkbox"/> Black Tar <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk b. Route (skin pop, IV): _____ <input type="checkbox"/> Unk c. Site: _____ <input type="checkbox"/> Unk d. Last used: _____ <input type="checkbox"/> Unk e. Where obtained: _____ <input type="checkbox"/> Unk f. Others ill (describe who, how many): _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Use any other recreational drugs? a. Type: _____ <input type="checkbox"/> Unk b. Route (oral, skin pop, IV): _____ <input type="checkbox"/> Unk c. Last used: _____ <input type="checkbox"/> Unk d. Where obtained: _____ <input type="checkbox"/> Unk e. Others ill (describe who, how many): _____ <input type="checkbox"/> Unk |

Comments: _____

Section 6: OPEN-ENDED DAILY HISTORY: I am now going to ask you about the activities, (*patient name*) participated in the 3 days before illness onset, including all the food eaten, and places (*patient name*) visited in the 3 days before (*patient*) got sick.

Note to interviewer: Go through the entire day, from the moment the patient woke up to the time he/she went to bed- there should be an account of every waking moment. Seven days are optimal, but the three days prior to illness would be most crucial. Use additional sheets of paper if recall is good for all seven days.

| Days before illness onset: 0 Date: (only ask about activities before onset) | Food eaten/ Activity | At Home | Outside Home (location) | Describe activity and all things consumed, including food, drink, supplements, drugs (i.e., attended school, attended birthday party or other event, went to work, etc) |
|---|-----------------------------|----------------|--------------------------------|---|
| Morning (wake up time-noon): ask about breakfast | | | | |
| Afternoon (noon-5PM): ask about lunch, snacks | | | | |
| Evening (5PM-9PM): ask about dinner | | | | |
| Night (9PM-bedtime); any snacks | | | | |

| Days before illness onset: 1 Date: (only ask about activities before onset) | Food eaten/ Activity | At Home | Outside Home (location) | Describe activity and all things consumed, including food, drink, supplements, drugs (i.e., attended school, attended birthday party or other event, went to work, etc) |
|---|-----------------------------|----------------|--------------------------------|---|
| Morning (wake up time-noon): ask about breakfast | | | | |
| Afternoon (noon-5PM): ask about lunch, snacks | | | | |
| Evening (5PM-9PM): ask about dinner | | | | |
| Night (9PM-bedtime); any snacks | | | | |

Section 6: OPEN-ENDED DAILY HISTORY (CONTINUED)

| Days before illness onset: 2 Date: (only ask about activities before onset) | Food eaten/ Activity | At Home | Outside Home (location) | Describe activity and all things consumed, including food, drink, supplements, drugs (i.e., attended school, attended birthday party or other event, went to work, etc) |
|---|-----------------------------|----------------|--------------------------------|---|
| Morning (wake up time-noon): ask about breakfast | | | | |
| | | | | |
| Afternoon (noon-5PM): ask about lunch, snacks | | | | |
| | | | | |
| Evening (5PM-9PM): ask about dinner | | | | |
| | | | | |
| Night (9PM-bedtime); any snacks | | | | |
| | | | | |

| Days before illness onset: 3 Date: (only ask about activities before onset) | Food eaten/ Activity | At Home | Outside Home (location) | Describe activity and all things consumed, including food, drink, supplements, drugs (i.e., attended school, attended birthday party or other event, went to work, etc) |
|---|-----------------------------|----------------|--------------------------------|---|
| Morning (wake up time-noon): ask about breakfast | | | | |
| | | | | |
| Afternoon (noon-5PM): ask about lunch, snacks | | | | |
| | | | | |
| Evening (5PM-9PM): ask about dinner | | | | |
| | | | | |
| Night (9PM-bedtime); any snacks | | | | |
| | | | | |

Section 7: EVENTS, PLACES, TRAVEL

Next, I would like to ask you a few questions about any events, gatherings, or travel (*patient name*) may have participated in the 7 days before the illness

| Yes | Maybe | No | Don't Know | Did (<i>patient name</i>): |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Travel outside your city of residence for work or pleasure? a. Place(s): _____ <input type="checkbox"/> Unk b. Dates of travel: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Attend any other events such as school events, church events, track meets, sporting events, fairs, festivals, wedding receptions, parties, picnics, etc.? a. Types of events: _____ <input type="checkbox"/> Unk b. Locations (cross-streets, city): _____ <input type="checkbox"/> Unk c. Dates: _____ <input type="checkbox"/> Unk d. Other ill attendees (describe who, how many): _____ <input type="checkbox"/> Unk e. Foods eaten: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Additional events, if any? a. Types of events: _____ <input type="checkbox"/> Unk b. Locations (cross-streets, city): _____ <input type="checkbox"/> Unk c. Dates: _____ <input type="checkbox"/> Unk d. Other ill attendees (describe who, how many): _____ <input type="checkbox"/> Unk e. Foods eaten: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Attend school/work? a. Name of school/place of employment: _____ <input type="checkbox"/> Unk b. Grade in school/ Occupation: _____ <input type="checkbox"/> Unk c. Locations (cross-streets, city): _____ <input type="checkbox"/> Unk d. Other ill persons (describe who, how many): _____ <input type="checkbox"/> Unk |

Comments:

Section 8: SOURCES OF FOOD AT HOME

Now I have a few questions about where the food came from that (*patient name*) ate **at home** in the 7 days before your illness began. This isn't necessarily where you shopped during that week, but where the food (*patient name*) ate came from. I'm going to list several types of stores, for each type please tell me the names of each store (*patient name*) would have eaten food from during the 7 days before you (*your child*) were sick.

1. Did you (your child) eat foods from: *Please check all that apply and list all sources in the table below.*
- Grocery stores or supermarkets
 - Warehouse stores (Costco, Sam's Club, etc.)
 - Small markets or mini markets (convenience stores, gas stations, etc.)
 - Ethnic specialty markets (Mexican, Asian, Indian, etc.)
 - Health food stores or co-ops
 - Farmer's markets, roadside stands, open-air markets, or food purchased directly from a farm
 - Fish or meat specialty shops (butcher's shop, etc.)
 - Other

| Store/Retail Name | City | Cross-streets/Address |
|-------------------|------|-----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Comments:

Section 9: SOURCES OF FOOD OUTSIDE THE HOME

Now I have a few questions about where the food came from that you (*patient name*) ate **outside your home**, such as restaurants or fast food chains. I'm going to list several types of restaurants, for each type please tell me the names of each place you (your child) would have eaten food from during the 7 days before you (your child) were sick.

1. Did you (your child) eat at any: *Please check all that apply and list all places in the table below.*

- | | | |
|--|---|--|
| <input type="checkbox"/> Food trucks, food stands/stalls | <input type="checkbox"/> Salad bar at a grocery store or restaurant | <input type="checkbox"/> Any take-out food from restaurant |
| <input type="checkbox"/> Mexican, El Salvadorian, Peruvian, or other Hispanic/Latino-style | <input type="checkbox"/> An event where food was served, such as a catered event, food festival, church or community meal, etc. | <input type="checkbox"/> School or other institutional setting |
| | | <input type="checkbox"/> Other |

| Restaurant/Eatery Name | Location | Foods Eaten | Date |
|------------------------|----------|-------------|------|
| | | | |
| | | | |
| | | | |
| | | | |

Comments:

Section 10: FOOD HISTORY

Now I have a few questions about other food items that you (*patient name*) ate in the 7 days before the illness.

***Note to interviewer: If patient has any leftovers of suspect food items, please have them save for potential testing. Conditions that are conducive to toxin production include high water, high pH, low salt, low sugar; prolonged incubation at room temperature, not heated to 65°C before eating, anaerobic environment.*

| Food Item | Yes | No | Unk | If Yes, Specify as Noted. | | |
|--|-----|----|-----|---|-------------------------------------|----------------|
| | | | | Details (type of food, how store, refrigerated, etc.) | Type of packaging, Labeling, if any | Where obtained |
| Any home-canned or jarred product (made at home or by friend/ family), such as preserved vegetables, spreads, jellies, etc). | | | | | | |
| Any fermented or otherwise home-preserved product (e.g. bean paste, tofu, pickles, fish, etc) | | | | | | |
| Dried or fermented meat not packaged at the store | | | | | | |
| Home made products marinated in oil (e.g., garlic or herb infused oils) | | | | | | |
| Unpasteurized juices (either fruit or vegetable, including carrot juice) | | | | | | |
| Vacuum packed foods | | | | | | |
| Olives or other vegetables kept in jars | | | | | | |

Section 10: FOOD HISTORY (CONTINUED)

| Food Item | Yes | No | Unk | If Yes, Specify as Noted. | | |
|--|-----|----|-----|---|-------------------------------------|----------------|
| | | | | Details (type of food, how store, refrigerated, etc.) | Type of packaging, Labeling, if any | Where obtained |
| Dips and spreads, especially home prepared or from a farmer's market | | | | | | |
| Any grain product (e.g. rice), including commercially prepared foods stored at inappropriate temperature prior to eating (e.g, foods that are meant to be refrigerated stored at room temperature) | | | | | | |
| Any soup or other ready to eat product packaged in plastic container, that are meant to be refrigerated stored at room temperature) | | | | | | |
| Dried salted fish (especially uneviscerated) | | | | | | |
| Any other seafood | | | | | | |
| Pre-prepared herbal teas (liquid form. Ready-to-drink) | | | | | | |
| Herbs or supplements | | | | | | |
| Any specialty or ethnic foods or snacks | | | | | | |
| Specialty prepared nutritional food or drink | | | | | | |
| Home brewed alcohol, such as pruno | | | | | | |
| Baked potato stored in foil | | | | | | |
| Other food items of interest | | | | | | |
| Untreated water | | | | | | |

Comments:

Section 11: OTHER EXPOSURES

We have covered a wide variety of foods and activities. After answering all these questions are there any other exposures (food, drinks, animals, activities, ill persons) that occurred in the 7 days before your (the patient's) illness onset?

Contact name (last, first) _____ Date of Birth _____

Section 12: CONTACT LIST

| Name | Relationship | Household Contact (Y/N) | Phone # | Email/ other | Interviewed (Y/N) |
|------|--------------|-------------------------|---------|--------------|-------------------|
| | | | | | |
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| | | | | | |
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Section 13: REMARKS