



Patient name (last, first) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**WNV DIAGNOSTIC TESTS**

| Type of Test      | Type of Specimen | Date Collected | Results | Name of Laboratory |
|-------------------|------------------|----------------|---------|--------------------|
| WNV IgM (EIA/IFA) |                  |                |         |                    |
| PRNT              |                  |                |         |                    |
| Other (Specify)   |                  |                |         |                    |

**EPIDEMIOLOGIC RISK FACTORS**

Currently pregnant .....  Yes  No  Unk If Yes, Week of gestation: \_\_\_\_\_

**Did the following events occur during the 4 weeks prior to your illness: Start of Exposure Period** \_\_\_/\_\_\_/\_\_\_

Donated blood .....  Yes  No  Unk If Yes, Date: \_\_\_/\_\_\_/\_\_\_

Donated organ .....  Yes  No  Unk If Yes, Date: \_\_\_/\_\_\_/\_\_\_

Received blood transfusion .....  Yes  No  Unk If Yes, Date: \_\_\_/\_\_\_/\_\_\_

Received organ transplant: .....  Yes  No  Unk If Yes, Date: \_\_\_/\_\_\_/\_\_\_

**BEHAVIOR**

**Activities during the 4 weeks prior to your illness:**

Did you have exposure to or bites from mosquitoes?  Yes  No  Unknown Dates/locations: \_\_\_\_\_

Did you do anything to protect yourself from mosquito bites?  Yes  No  Unknown

If Yes, did you use insect repellent?  Yes  No  Unknown What did you use as a repellent? \_\_\_\_\_

If No, why not? \_\_\_\_\_

Did you travel outside of California?  Yes  No  Unknown Dates/locations: \_\_\_\_\_

Did you travel outside the U.S.?  Yes  No  Unknown Dates/locations: \_\_\_\_\_

**Have you:**

Ever traveled outside the U.S.....  Yes  No  Unk Dates/Locations: \_\_\_\_\_

Ever received yellow fever vaccine .....  Yes  No  Unk Date of vaccination: \_\_\_/\_\_\_/\_\_\_

**RESIDENCE**

**Describe your main residence during the 4 weeks prior to your illness:**

Did you reside in a:  House  Townhouse  Condo/Apartment  Other (specify) \_\_\_\_\_

Did your home residence have screens for windows or doors?  Yes  No  Unknown

If Yes, did any of them have holes or defects that would allow mosquitoes to enter?  Yes  No  Unknown

Did your home residence have air conditioning?  Yes  No  Unknown

If Yes, how often did you use it instead of leaving windows or doors open?  Always  Most of the time  Sometimes  Rarely  Never

Did you have water that does not dry up for several days in and around your home residence (unmaintained pools and fountains or potted plants with saucers)? This is called standing water.  Yes  No  Unknown

If Yes, how often did you drain the standing water?  More than 4 times  3 to 4 times  1 to 2 times  0 times

Did you have rain barrels?  Yes  No  Unknown If Yes, check the measures you took to keep mosquitoes out of rain barrels.

Covered all openings  Emptied regularly  Used mosquito dunks  None

Are you aware of standing water in your neighborhood (such as neighbors' pools, nearby ponds, or street gutters)?  Yes  No  Unknown

If Yes, describe. \_\_\_\_\_

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**EPIDEMIOLOGIC RISK FACTORS (continued)**

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Activities during the 2 weeks prior to illness: Start of Exposure Period \_\_\_/\_\_\_/\_\_\_

Please list 2 locations aside from your home residence that you spent the most time? (Specify address if possible)

a. \_\_\_\_\_ b. \_\_\_\_\_

Please estimate the total hours you spent outside per day: \_\_\_\_\_

Where did you spend most of your time outside? \_\_\_\_\_

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**KNOWLEDGE**

Did you know about West Nile Virus prior to your illness?  Yes  No  Unknown

If Yes, where did you first hear about West Nile Virus? Check all that apply.

News articles (online or print)  Television  Radio  Social Media  Word of mouth  Other: Specify. \_\_\_\_\_

Where do you usually find information about health and diseases? Check all that apply.

News articles (online or print)  Television  Radio  Social Media  Word of mouth  Other: Specify. \_\_\_\_\_

What is your education level?  Below HS level  GED/HS diploma  Some college  College and above

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**REMARKS**

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Investigator Name:

Interview Date:

Telephone Number:

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