

WELLSPRING FOUNDATION (2006-225)

proxy? Phone _____

Age _____ Sex M F

Interviewed by _____ on _____

Y	?	N	LEAD-IN QUESTIONS/ DID YOU...	[1]
A	<input type="checkbox"/>	<input type="checkbox"/>	attend the Foundation Dinner/Open House at the Wellspring last Thursday night (Nov 16)?	

FOOD EXPOSURES

Let me ask you about the items that were available at the open house.

About what time did you first start eating? _____

For each item, give me a "yes" or "no" answer if you remember eating or even tasting it.

<p>[2] Y ? N Integrative Medicine (Mexican)</p> <p>A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chicken fajitas</p> <p>B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> scallops</p> <p>C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> shredded beef</p> <p>D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chicken chingalinga (flauta)</p> <p>E <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nacho chips</p> <p>F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cheese jalapeño sauce</p> <p>G <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> lettuce</p> <p>H <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> olives</p> <p>I <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> grated cheese</p> <p>J <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> salsa</p> <p>K <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sour cream</p> <p>_____</p>	<p>[3] Y ? N FOUNTAIN AREA (Seafood)</p> <p>A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> prawns</p> <p>B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> crab legs</p> <p>C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> oysters</p> <p>D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cocktail sauce</p> <p>E <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hot sauce</p> <p>F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> any kind of sushi</p> <p>G <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> California roll</p> <p>H <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> vegetarian sushi</p> <p>I <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____ sushi (other kind)</p> <p>J <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> lemons</p> <p>K <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> crackers</p> <p>_____</p>	<p>[4] Y ? N FITNESS CENTER (Italian)</p> <p>A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ravioli</p> <p>B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> curly pasta (fusili)</p> <p>C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> marinara sauce</p> <p>D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> alfredo sauce</p> <p>E <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> pesto sauce</p> <p>F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sausage</p> <p>G <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chicken</p> <p>H <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> prawns</p> <p>I <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> olive</p> <p>J <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> artichoke hearts</p> <p>K <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mushrooms</p> <p>L <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> sundried tomatoes</p> <p>M <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> rolls</p> <p>N <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> margarine</p> <p>_____</p>
<p>[5] Y ? N BISTRO (Snacks)</p> <p>A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mini-hamburgers ("sliders")</p> <p>B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> bun</p> <p>C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> pickles</p> <p>D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> root beer</p> <p>E <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> vanilla ice cream</p> <p>_____</p>	<p>[6] Y ? N WOODLANDS (Conf Center)</p> <p>A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> chocolate cake</p> <p>B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> apple/cranberry tart</p> <p>C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> any fresh fruit from platter</p> <p>D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> honeydew</p> <p>E <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> watermelon</p> <p>F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> canteloupe</p> <p>G <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> strawberries</p>	<p>OTHER</p> <p>H <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did you drink anything with ice?</p>

[7] Y ? N	OTHER QUESTIONS FOR EVERYBODY
A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did you take any food home from the reception?
B	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did anyone in your household who did not go to the event later become ill? (If yes, write in onset, sx, etc.)
Z	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have you yourself been sick at all with diarrhea or vomiting since the event?

if this person has not been sick, STOP HERE. If they have had symptoms, CONTINUE to the last page.

This page is only for people who got sick. Discard or ignore for those who did not become ill.

Let me read you a list of symptoms. For each one, give me a "yes" or "no." Did you have any...

Y ? N	SIGNS AND SYMPTOMS	Y ? N	
H <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	headache	L <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	shaking chills
N <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	nausea	D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	any diarrhea or loose stools
V <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	vomiting	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	if yes to diarrhea, did you have 3 or more loose stools in any 24-hour period?
M <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	myalgia (muscle aches)	B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	any blood in stools
C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	abdominal (stomach, belly) cramps	Z <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	other _____
T <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	unusual fatigue (feeling tired)		
F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	fever (if yes, <input type="checkbox"/> subjective or _____ ° (max.)		

ONSET AND DURATION

Get precise answers for onset times. Without a date **and time**, it's hard to make a decent epi curve. Estimates are OK. Prompt as needed: "What is your best guess of the time?" Don't let them get away with vague stuff like "morning" or "after midnight." Be careful with times such as "midnight" or early morning hours—which day do they mean? By "2am Friday night," for example, do they really mean Saturday morning? Keep probing until it is unambiguous. Write down what they mean—not what they say. Midnight exactly is graphed as 11:59 pm.

November 2006						
S	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

On what date did you first feel sick?

- Thurs, Nov 16
- Fri, Nov 17
- Sat, Nov 18
- Sun, Nov 19
- Mon, Nov 20
- _____

At what time did you first feel sick? [PRESS FOR A SPECIFIC TIME!!!]

- _____ am
- noon
- _____ pm
- midnight (very end of day)

[If applicable] On what day did you start having the vomiting or diarrhea (whichever came first)?

Note: the point here is to capture the onset time of some "hard" symptom, in case they had a "soft" prodrome.

- Thurs, Nov 16
- Fri, Nov 17
- Sat, Nov 18
- Sun, Nov 19
- Mon, Nov 20
- _____

[If applicable] At what time did the vomiting/diarrhea begin? [PRESS FOR A SPECIFIC TIME!!!]

- _____ am
- noon
- _____ pm
- midnight (end of day)

Were your symptoms intermittent? I.e., did you feel better for a day or two and then get sick again? yes no

Are you still having any vomiting/diarrhea now? yes no

If no, how long did the vomiting/diarrhea last? _____ minutes _____ hours _____ days

Overall, over how long a time did you feel ill? _____ minutes _____ hours _____ days

*If symptoms were intermittent, get the spread from beginning to end. For example, if they were sick on Monday, Wed, and Friday, but felt OK on Tuesday and Thursday, mark "5 d", not 3.

MISCELLANY (check all that apply; provide details [names, dates, phone numbers, etc.] at right.)

Y ? N	Did you/Are you...	
W <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	miss work or school?	if yes, how many days? _____
P <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	see any clinician?	if yes, whom?
E <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	visit an ER?	if yes, specify
S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	give a stool specimen?	if yes, when/to whom <input type="checkbox"/> to PHL <input type="checkbox"/> to private lab _____
C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	already culture-positive?	if yes, specify
F <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	[if not] willing to provide specimen?	
H <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	get admitted to hospital overnight?	hospital _____ admitted ___/___/___ discharged ___/___/___

Give standard info re handwashing. Ask if they work in any sensitive occupation.