

Legionellosis Hypothesis-Generating Questionnaire

<Instructions to the interviewer appear in italics. Please read the entire questionnaire before beginning the interview.>

<After confirming a case of Legionnaires' disease or Pontiac fever and completing the CDC Legionellosis Case Report Form, this form can be used to collect additional epidemiologic data that may be useful in detecting outbreaks or in a future cluster/outbreak investigation. This form may be added to your state's electronic notifiable disease surveillance system in whole or in part for routine data collection. A more detailed questionnaire that is customized to the outbreak location should be completed if the case is associated with a known outbreak.>

<What was the patient's outcome? RECOVERED STILL ILL DIED>

Interviewer Identification

Date of interview: _____ Interviewer's Name: _____
Health Department: _____ Phone Number: _____ E-mail: _____

Patient Contact Information

Name: _____ Age: _____ Sex: M F
City: _____ State: _____ Zip: _____ County: _____
Daytime Phone: _____ Evening phone: _____

Surrogate Contact Information *<List surrogate contact information if patient is too unwell or has died.>*

Name: _____ Age: _____ Sex: M F
City: _____ State: _____ Zip: _____ County: _____
Daytime Phone: _____ Evening phone: _____
Relationship to patient: _____

Hello, my name is _____ and I'm calling from _____. I'm calling about your recent Legionnaires' disease *<or Pontiac fever>* illness. Legionnaires' disease *<or Pontiac fever>* is a reportable disease, which means that healthcare providers must report cases to public health so that we can determine if there is a public health concern. I'd like to ask you a few questions about your exposures during the 10 days before you got sick. You do not have to answer any of the questions, but your cooperation is appreciated. Do you have a few minutes to talk? If not now, when would be a good time for me to call back?

I have that your first symptom started on *<insert onset date>* _____. Is this correct?

YES NO Not sure

If no, what was the first date you started feeling sick? _____

<The exposure period includes the 10 days before illness onset. List dates of exposure period:
from _____ to _____. >

Exposure Information

I'd like to ask you some questions about your travel and exposures during the **10 days before you got sick**. The time period I'm asking about is between _____ and _____. During this 10 day period, did you:

1.) Visit or work in a hospital? Yes No Not sure

a.) If yes, check all that apply:

	Date(s)	Name & City of Hospital	Reason for Visit
<input type="checkbox"/> Inpatient	Admission _____ Discharge _____		
<input type="checkbox"/> Outpatient			
<input type="checkbox"/> Visitor			
<input type="checkbox"/> Employee			
<input type="checkbox"/> Volunteer			

Comments: _____

2.) Visit a doctor's office, clinic, or dentist office? Yes No Not sure

a.) If yes, check all that apply:

	Date(s)	Name of Doctor	Name & City of Practice
<input type="checkbox"/> Doctor's office or clinic			
<input type="checkbox"/> Dentist			

Comments: _____

3.) Visit, reside, or work in a long term care facility, nursing home, assisted living facility, or senior living facility? Yes No Not sure

a.) If yes, check all that apply:

	Exposure	Date(s)	Name & City of Facility
<input type="checkbox"/> Long term care facility (includes: nursing home, rehab facility, or skilled nursing facility)	<input type="checkbox"/> Resident		
	<input type="checkbox"/> Visitor		
	<input type="checkbox"/> Employee		
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Resident		
	<input type="checkbox"/> Visitor		
	<input type="checkbox"/> Employee		

<input type="checkbox"/> Senior Living (includes retirement homes <u>without</u> skilled nursing or personal care)	<input type="checkbox"/> Resident		
	<input type="checkbox"/> Visitor		
	<input type="checkbox"/> Employee		

Comments: _____

4.) During this 10 day period before you got sick (_____ to _____), did you spend any nights away from home (excluding healthcare settings)? Yes No Not sure

a.) If yes, complete the following table.

Country	State	City	Accommodation Name	Address	Room No.	Dates of Stay	
						Arrival	Departure

Comments: _____

5.) Did you visit a hotel without staying overnight (e.g., dinner, wedding)? Yes No Not sure

a.) If yes, describe:

Reason for visit	Date(s)	Name of Hotel	Address	City	State

Comments: _____

6.) Did you attend any other conventions or public gatherings? Yes No Not sure

a.) If yes, describe:

Type of Event	Date(s)	Name of Facility	Location of Facility

Comments: _____

7.) In the 10 days before you before you got sick (_____ to _____), did you have exposure to any of the following, either while traveling or at home?

Exposure	YES	NO	UNK	Location	Date(s)
Hot tub or whirlpool spa					
Sat NEAR a working hot tub or whirlpool spa but did not get in					
Jacuzzi					
Pool					
Recreational misters					
Steam room or wet sauna					
Decorative fountain					
Humidifier					
Shower (away from home only)					

Comments: _____

8.) Did you use a nebulizer, CPAP, BiPAP, or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma, or for any other reason? Yes No Not sure

a.) If yes, complete the following table.

Type of device	Date(s)	Location

b.) If yes, does this device use a humidifier or misty water? Yes No Not sure

i.) If yes, describe what type of water is used in the device (e.g., sterile, distilled, tap) and how it is cleaned. _____

9.) Do you recall any general construction, plumbing projects, water main breaks, or water line work either at your home or while traveling in those 10 days? Yes No Not sure

a.) If yes, complete the following table.

Type of work	Date(s)	Location

Comments: _____

10.) During the 10 days before you before you got sick (_____ to _____), did you shop at a grocery store where there were mister machines for the fruit and vegetables? Yes No Not sure

a.) If yes, complete the following table.

Name of store	Date(s)	Location

Comments: _____

11.) Did you shop at a mall, department store, or home improvement store (e.g., Wal-Mart, Home Depot)? Yes No Not sure

a.) If yes, complete the following table.

Name of store	Date(s)	Location

Comments: _____

12.) Do you work or volunteer full or part time? Yes No Not sure

a.) If yes, complete the following table.

Job description	Company	Location	Any exposure to misty water?

Comments: _____

13.) Do you know anyone else with similar symptoms? Yes No Not sure

a.) If yes, complete the following table.

Name	Phone	State of Residence	Details of shared exposure

Comments: _____

Medical History

Now I'm going to ask a few questions about your medical history and health behaviors.

14.) Have you ever been told by a healthcare provider that you had:

Condition	Check one:			Comments
	YES	NO	Not Sure	
Chronic kidney disease				
Weakened immune system (Cancer, Chemotherapy, Radiation Therapy, immunosuppressive meds, HIV, organ transplant)				
Diabetes				
Chronic lung disease (COPD, emphysema)				
Asthma				
Heart disease or CHF				
Liver disease				
Other conditions				

15.) Health behaviors:

	Check one:		Quantity per day (packs or drinks)	Duration (years)
	YES	NO		
Are you currently a smoker?				
Are you a former smoker?				
Do you drink alcohol?				

That is the end of the questionnaire! Thank you for your time. Do you have any questions about Legionnaires' disease <or Pontiac fever> that I can help answer? If you have any questions or remember any further details, you may reach me at _____. Thank you!!!