Kansas Department of Health and Environment
Epidemiology and Public Health Informatics

Arboviral Disease – Neuroinvasive and Non-neuroinvasive Form

INTERVIEW

EpiTrax # _____ Interviewer Name:_____

Number of Call Attempts:_____ Date of Interview (must enter MM/DD/YYYY):_____

Follow-up Status: ☐ Interviewed
☐ Refused Interview
☐ Lost to Follow-Up*

Respondent was: ☐ Self
☐ Parent
☐ Spouse
☐ Other, *Specify*:_____

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

DEMOGRAPHICS

Birth gender: ☐ Male ☐ Female

Date of birth: _____

Age:_____

Hispanic/Latino Origin:
☐Yes
☐No
☐Unknown

How would you describe your race?
☐ White
☐ Black/African American
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____
☐ Unknown

CLINICAL

Did you have any symptoms? ☐ Yes ☐ No ☐ Unknown

What date did you start to have symptoms of illness?
Onset Date: _____
Onset Time: _____

Were you hospitalized? ☐ Yes ☐ No ☐ Unknown

Did the patient die? ☐ Yes: Date of death_____ ☐ No ☐ Unknown

If yes, hospital name:_____

Admit date: _____

Discharge date: _____

Are you pregnant? ☐Yes
☐No
☐Unknown If yes, expected delivery date:_____

LABORATORY

If serology was done, was there a fourfold change in antibody titer between the two serum specimens?

☐ Yes ☐ No

EPIDEMIOLOGICAL

Imported from:

☐ Indigenous ☐ Outside U.S. ☐ Outside of County ☐ Out of State ☐ Unknown

INVESTIGATION

A. Symptoms & Signs

• Fever:	☐Yes ☐ No ☐ Unknown
If YES: o Measured fever greater than or equal to 38°C or 100.4°F	☐Yes ☐ No ☐ Unknown
o Subjective Fever or Chills	☐Yes ☐ No ☐ Unknown
If NO: o Used over-the-counter medication that reduces fevers	☐Yes ☐ No ☐ Unknown
o Used treatments that suppress the immune system	☐Yes ☐ No ☐ Unknown
o Has an immunosuppressive condition	☐Yes ☐ No ☐ Unknown
Describe immunosuppressive condition	
• Chills or Rigors?	☐Yes ☐ No ☐ Unknown
• Headache?	☐Yes ☐ No ☐ Unknown
• Fatigue or Malaise?	☐Yes ☐ No ☐ Unknown
• Rash?	☐Yes ☐ No ☐ Unknown
• Nausea or Vomiting?	☐Yes ☐ No ☐ Unknown
• Diarrhea?	☐Yes ☐ No ☐ Unknown
• Muscle weakness/pain?	☐Yes ☐ No ☐ Unknown
• Joint pains?	☐Yes ☐ No ☐ Unknown
• Arthritis?	☐Yes ☐ No ☐ Unknown
• Paresis or Paralysis?	☐Yes ☐ No ☐ Unknown
• Stiff neck?	☐Yes ☐ No ☐ Unknown

• Ataxia?	☐Yes ☐ No ☐ Unknown
• Parkinsonism or Cogwheel Rigidity?	☐Yes ☐ No ☐ Unknown
• Seizures?	☐Yes ☐ No ☐ Unknown
• Altered Mental Status?	☐Yes ☐ No ☐ Unknown
• Other symptoms? o If yes, specify:	☐Yes ☐ No ☐ Unknown

B. Complications

Did a health care provider ever tell you that you had any of the following conditions?

• Meningitis	☐Yes ☐ No ☐ Unknown
• Encephalitis	☐Yes ☐ No ☐ Unknown
• Acute flaccid paralysis	☐Yes ☐ No ☐ Unknown

C. Exposure – Risk Factors

• Laboratory acquired?	☐Yes ☐ No ☐ Unknown
• Blood donor?	☐Yes ☐ No ☐ Unknown
• Blood product recipient?	☐Yes ☐ No ☐ Unknown
• Organ donor?	☐Yes ☐ No ☐ Unknown
• Organ transplant recipient?	☐Yes ☐ No ☐ Unknown
• Breast fed infant?	☐Yes ☐ No ☐ Unknown
• Infected in utero?	☐Yes ☐ No ☐ Unknown

D. Exposure – Travel History

Did you travel outside of your Kansas County in the 15 days before the illness began? ☐ Yes ☐ No ☐ Unknown

- City, County in Kansas you traveled to: _____
- Date departed:_____ Date returned:_____

Did you travel outside of Kansas in the 15 days before the illness began? ☐ Yes ☐ No ☐ Unknown

- City, County in Kansas you traveled to: _____
- Date departed:_____ Date returned:_____