

Epi CASE Survey

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Clearance Officer, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30329
ATTN: PRA (0923-0051)

For official interviewer use only

Household ID _____ Participant ID _____ Interviewer Initials _____
Interview location _____

Form Approved
OMB No. 0923-0051

Confirmation of Identity (Please select one)

Social Security ___ - ___ - ____

Driver's license: State ___

Number _____ exp ___ / ___ / ____

State ID: State ___

Number _____ exp ___ / ___ / ____

Other ID (describe) _____

Registrant Information

1. Last name _____ First name _____ MI ___ 2. Date of Birth (mm/dd/yyyy) ___/___/____

3. Sex Male Female → (select one) Not pregnant Pregnant → estimated due date (mm/dd/yyyy) ___/___/____

4. Home Address

Street _____ City _____ County _____

State _____ ZIP _____ 5. Email address _____

6. What social media accounts do you use. This helps us know how to best communicate with you. (check all that apply)

Facebook Twitter Instagram Other _____ Refused

7. What are the best telephone numbers to reach you?

A. (___) ___ - ____ Cell Home Work

B. (___) ___ - ____ Cell Home Work

Emergency Contact Information (Prefer someone that lives at a different address)

8. Contact's Last name _____, First Name _____ MI _____

9. Contacts phone numbers

A. (___) ___ - ____ Cell Home Work B. (___) ___ - ____ Cell Home Work

10. Contact's Address

Street _____ City _____ County _____

State _____ ZIP _____ 11. Contact's Email address _____

16. Did you go to a Community Resource Center (CRC)? Yes No Unsure

17. If you went to a Community Resource Center (CRC) what tracking number did they give you? _____

18. Were you decontaminated (i.e. your clothing was removed and/or your body was washed, etc.)? Yes No Unsure

19. Did you shelter-in-place? Yes No Unsure

20. Did you evacuate? Yes No Unsure

21. If you evacuated did you take any pets with you?

Yes, I evacuated with all my pets Yes, I evacuated some of my pets

No, I don't have any pets No, I left them at home Unsure

22. As a result of this incident, are you personally in need of anything? (check all that apply)

Medicine or medical supplies Medical care Mental health care Water Shelter Food Utilities

Transportation Other, specify _____ Don't know/refused

23. How many children younger than 18 years of age were in your immediate care during the incident _____

(Note to survey developer, if electronic generate the corresponding number of children child 1-child N for Q21 and Q 22)

Child 1 Last name _____, First name _____ MI _____

b. Age (if less than 1, put 1) _____ c. Sex Male Female

SYMPTOMS

24. Did you or your children have any of the following types of symptoms start or worsen after the incident?

Answer each row of symptoms <input type="checkbox"/> <u>If nobody had symptoms check this box and go to the conclusion</u>	Self	Child 1	Child 2
Any symptoms affecting your whole body like fever, chills, weakness, or all over body aches/pains?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms affecting your eyes such as tearing, pain, burning or vision problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms related to your ears, nose and throat such as pain in your ear, nose or throat, ringing in your ears, difficulty hearing, runny; stuffy, burning or bleeding nose or throat, or odor on your breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms related to your skin such as skin irritation, pain, burning, blistering, rash, discoloration, sweating, cuts, bruising, bleeding or hair loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms related to your kidneys or urinary tract like difficulty or pain with urinating, blood in your urine, or painful kidneys (often feels like lower back pain)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms related to your nervous system such as headache, dizziness, seizures, numbness, loss of consciousness or balance, difficulty concentrating/remembering/or speaking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms related to your heart and lungs like breathing problems {including asthma, coughing or wheezing, pneumonia, bronchitis}; blood pressure and heart rate abnormalities; or chest tightness or pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Any symptoms related to your muscles, joints, or bones such as pain, weakness, tremors or twitching of muscles, joint swelling or pain, broken or dislocated bone, sprains or whiplash?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Symptoms involving your mood, thought, or sleep such as feeling anxious, afraid, irritable, hopeless, sad, tired, suspicious, trouble sleeping, or having hallucinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Symptoms of your stomach or intestines , such as nausea, vomiting or diarrhea, blood in your stool or vomit, abdominal pain, difficulties with bowel movements, or bowel perforation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
25 For radiological and nuclear incidents only If you had repeated vomiting after the incident, how long after the incident [date and time] did it start?	<input type="checkbox"/> < 1 hour <input type="checkbox"/> 1-2 hours <input type="checkbox"/> 3-6 hours <input type="checkbox"/> > 6 hours <input type="checkbox"/> Unsure <input type="checkbox"/> No vomiting	<input type="checkbox"/> < 1 hour <input type="checkbox"/> 1-2 hours <input type="checkbox"/> 3-6 hours <input type="checkbox"/> > 6 hours <input type="checkbox"/> Unsure <input type="checkbox"/> No vomiting	<input type="checkbox"/> < 1 hour <input type="checkbox"/> 1-2 hours <input type="checkbox"/> 3-6 hours <input type="checkbox"/> > 6 hours <input type="checkbox"/> Unsure <input type="checkbox"/> No vomiting
26. Did you or your children receive medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Conclusion: Thank you for your time. Would you like a copy of this form mailed or emailed to you for your records?