

BOX 1: CASE-PATIENT INFORMATION		
Case-patients = adults and children >1 month of age. For fetal or neonatal infections, the MOTHER is the case-patient.		
Patient's name: _____ Surrogate's name: _____		
Patient's street address: _____		
City: _____ State: _____ Zip: _____		
Phone numbers: (h) _____ (w) _____ (m) _____		
Hospital name(s): _____ Hospital contact name(s): _____		
Hospital contact numbers: _____		
<i>-----detach here to remove personal identifiers if necessary</i>		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity (check one):	Race (check all that apply):
State of residence: _____	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> African American/Black
Age: _____	<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Asian
DOB: ____/____/____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
State or local epi case ID: _____		<input type="checkbox"/> Native American/Alaska Native
CDC outbreak (EFORS) ID: _____		<input type="checkbox"/> White
		<input type="checkbox"/> Unknown

BOX 2: IS LISTERIA CASE ASSOCIATED WITH PREGNANCY? (Illness in pregnant woman, fetus, or neonate ≤1 month)	
<input type="checkbox"/> Yes	<i>If yes, skip to Box 4.</i>
<input type="checkbox"/> No	<i>If no, continue with Box 3.</i>
<input type="checkbox"/> Unknown	<i>If unknown, continue with Box 3.</i>

BOX 3: CASES NOT ASSOCIATED WITH PREGNANCY (Illness in non-pregnant adults and children > 1 month of age)			
Type(s) of specimen(s) that grew <i>Listeria (check all that apply)</i>	Specimen collection date	Submitting Lab (state, city, county)	State Public Health Lab Isolate ID Number <i>(important: must have at least one)</i>
<input type="checkbox"/> Blood	____/____/____		
<input type="checkbox"/> CSF	____/____/____		
<input type="checkbox"/> Stool	____/____/____		
<input type="checkbox"/> Other _____	____/____/____		
<input type="checkbox"/> Other _____	____/____/____		
Type(s) of illness (check all that apply)	Was patient hospitalized for listeriosis?	Patient's outcome	
<input type="checkbox"/> Bacteremia/sepsis	<input type="checkbox"/> Yes <i>If yes:</i>	<input type="checkbox"/> Survived	
<input type="checkbox"/> Meningitis	Admit date: ____/____/____	<input type="checkbox"/> Died	
<input type="checkbox"/> Febrile gastroenteritis	Discharge date: ____/____/____	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Still hospitalized		
<input type="checkbox"/> Unknown	<input type="checkbox"/> No		
	<input type="checkbox"/> Unknown		

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the 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 Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).

Please send completed forms to: Enteric Diseases Epidemiology Branch, Centers for Disease Control and Prevention, Mailstop A-38, Atlanta, GA 30338. Fax (404) 639-2206

BOX 4: CASES ASSOCIATED WITH PREGNANCY (Illness in pregnant woman, fetus, or neonate ≤1 month of age)			
Type(s) of specimen(s) that grew <i>Listeria</i> (check all that apply)	Specimen collection date	Submitting Lab (state, city, county)	State Public Health Lab Isolate ID Number (important: must have at least one)
<input type="checkbox"/> Blood from mother	___/___/___		
<input type="checkbox"/> Blood from neonate	___/___/___		
<input type="checkbox"/> CSF from mother	___/___/___		
<input type="checkbox"/> CSF from neonate	___/___/___		
<input type="checkbox"/> Stool from mother	___/___/___		
<input type="checkbox"/> Placenta	___/___/___		
<input type="checkbox"/> Amniotic fluid	___/___/___		
<input type="checkbox"/> Other _____	___/___/___		
<input type="checkbox"/> Other _____	___/___/___		

BOX 4 (CONTINUED): CASES ASSOCIATED WITH PREGNANCY

Outcome of pregnancy (single gestation or twin 1) (check one)	Weeks of gestation	Date	Outcome of pregnancy (twin 2) (check one)	Weeks of gestation	Date
<input type="checkbox"/> Still pregnant		___/___/___	<input type="checkbox"/> Still pregnant as of: ___/___/___		___/___/___
<input type="checkbox"/> Fetal death (miscarriage or stillbirth)		___/___/___	<input type="checkbox"/> Fetal death (miscarriage or stillbirth)		___/___/___
<input type="checkbox"/> Induced abortion		___/___/___	<input type="checkbox"/> Induced abortion		___/___/___
<input type="checkbox"/> Delivery (live birth)		___/___/___	<input type="checkbox"/> Delivery (live birth)		___/___/___
<input type="checkbox"/> Other _____		___/___/___	<input type="checkbox"/> Other _____		___/___/___

Type(s) of illness in mother (check all that apply)	Type(s) of illness in neonate (twin 1) (check all that apply)	Type(s) of illness in neonate 2 (twin 2) (check all that apply)
<input type="checkbox"/> Bacteremia/sepsis	<input type="checkbox"/> Bacteremia/sepsis	<input type="checkbox"/> Bacteremia/sepsis
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Febrile gastroenteritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Amnionitis	<input type="checkbox"/> Granulomatosis infantisepticum	<input type="checkbox"/> Granulomatosis infantisepticum
<input type="checkbox"/> Non-specific "flu-like" illness	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> None	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown		

Was mother hospitalized for listeriosis?	Was neonate (twin 1) hospitalized for listeriosis?	Was neonate 2 (twin 2) hospitalized for listeriosis?
<input type="checkbox"/> Yes <i>If yes:</i> Admit date: ___/___/___ Discharge date: ___/___/___ <input type="checkbox"/> Still hospitalized	<input type="checkbox"/> Yes <i>If yes:</i> Admit date: ___/___/___ Discharge date: ___/___/___ <input type="checkbox"/> Still hospitalized	<input type="checkbox"/> Yes <i>If yes:</i> Admit date: ___/___/___ Discharge date: ___/___/___ <input type="checkbox"/> Still hospitalized
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

Mother's outcome	Neonate's (twin 1's) outcome	Neonate 2's (twin 2's) outcome
<input type="checkbox"/> Survived	<input type="checkbox"/> Survived	<input type="checkbox"/> Survived
<input type="checkbox"/> Died	<input type="checkbox"/> Died	<input type="checkbox"/> Died
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

CASE-PATIENT INTERVIEW	
Date of interview(mm/dd/yyyy): ___/___/____	Initials of interviewer: _____
Interviewee: <input type="checkbox"/> Case-patient <input type="checkbox"/> Surrogate <input type="checkbox"/> Unknown	
If surrogate, relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other, Specify _____	
When did your illness begin? (Onset of illness) (mm/dd/yyyy): ___/___/____ <input type="checkbox"/> Not applicable (e.g. pregnant woman without clinical illness)	
During the 4 weeks before your illness (<i>delivery date</i>), were you admitted to a hospital (≥overnight)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
During the 4 weeks before your illness (<i>delivery date</i>), were you a resident in a nursing home or other long term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
If yes, Date of admission (mm/dd/yyyy) ___/___/___	
Date of discharge (mm/dd/yyyy) ___/___/___ or <input type="checkbox"/> Still hospitalized or residing in facility	
During the 4 weeks before your illness (<i>delivery date</i>), did you travel to a state outside your state of residence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
If yes, please list states visited: _____	
During the 4 weeks before your illness (<i>delivery date</i>), did you travel outside the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
If yes, name of country visited _____	
If yes, Date of departure from U.S. (mm/dd/yyyy) ___/___/___	
Date of return to U. S. (mm/dd/yyyy) ___/___/___	
Which of the following symptoms were associated with illness? (<i>read each</i>)	
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Diarrhea (≥3 loose stools/day) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Preterm labor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Muscle Aches <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Stiff Neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

FOOD HISTORY
INSTRUCTIONS FOR INTERVIEWER: Ask case-patient about the food he/she consumed during the 4 weeks before his/her Listeria SPECIMEN COLLECTION DATE. In the event of a fetal death or neonatal infection (<1 month of age), the MOTHER is the case-patient, and she should be asked about her food history during the 4 weeks before DELIVERY. Please refer to patient as “you” if interviewing the case-patient directly; if interviewing a surrogate, please use “he” or “she.”

INSTRUCTIONS TO READ TO CASE-PATIENT (OR SURROGATE):
I am interested in the foods you ate during the 4 weeks before your illness (<i>delivery</i>). I see that you had a positive test for listeriosis (<i>delivered</i>) on ___/___/____. For most of the interview, I will be asking you questions about the 4 weeks before this date, that is, from ___/___/___ (date 4 weeks before) through ___/___/___ (specimen collection/delivery date). (<i>Have patient get calendar for reference if possible.</i>) First I'd like to ask you about where the foods you ate were purchased. I am going to read you a list of places where food can be purchased. For each, please tell me if you ate food purchased from that type of place in the four week time period. I know that it can be difficult to remember that far back, but please do the best you can. If you're not sure, please tell me whether it's likely or unlikely that you ate food purchased from that location.
I. FOOD PURCHASE HISTORY
A. Grocery stores: Did you eat food purchased from any grocery stores during the 4 week time period? (<i>Please read all options.</i>) <input type="checkbox"/> Yes <input type="checkbox"/> It's likely <input type="checkbox"/> It's unlikely <input type="checkbox"/> No If yes or likely,

Listeria Case Form

Patient State Laboratory ID No. _____

Store Name	Street Address	City	County	State
1.				
2.				
3.				
4.				
5.				
6.				
7.				

B. Delis, small markets, farmers' markets: Did you eat food purchased from any delicatessens, small local markets, other small shops, or farmers' markets during the 4 week period? Yes It's likely It's unlikely No *If yes or likely,*

Store Name	Street Address	City	County	State
1.				
2.				
3.				
4.				
5.				
6.				
7.				

C. Restaurants: Did you eat food from any restaurants, including sit-down, fast-food, and take-out restaurants during the 4 week period?

Yes It's likely It's unlikely No *If yes or likely,*

Restaurant Name	Street Address	City	County	State	Dining dates (mm/dd/yyyy)
1.					___/___/___
2.					___/___/___
3.					___/___/___
4.					___/___/___
5.					___/___/___
6.					___/___/___
7.					___/___/___

D. Other venues: cafeterias, concession stands, institutions: Did you eat food purchased or obtained from any other venues, such as school cafeterias, concession stands, street vendors, institutions (e.g. hospital food), local farms, or private vendors during the 4 week period?

Yes It's likely It's unlikely No *If yes or likely,*

Name	Street Address	City	County	State	Dining dates (mm/dd/yyyy)
1.					___/___/___

Listeria Case Form

Patient State Laboratory ID No. _____

2.					__/__/__
3.					__/__/__
4.					__/__/__
5.					__/__/__
6.					__/__/__
7.					__/__/__

II. FOOD CONSUMPTION HISTORY
INSTRUCTIONS FOR INTERVIEWER: Please read all options to case-patient in each category. For the names of purchase sites, it is preferable to use codes from Section I above, e.g. A1 for first grocery store, A3 for third grocery store, C5 for fifth restaurant. A DELI COUNTER serves portions or helpings of salads, cheeses, and meats sliced ON-SITE at a specified counter within a grocery store, food market, or delicatessen. Foods sliced and packaged AT the FACTORY and sold as pre-packaged containers in self-serve refrigerated display cases are NOT considered to be from a deli counter

INSTRUCTIONS TO READ TO CASE-PATIENT (OR SURROGATE):
 Now I'd like to ask you about the foods that you ate between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date). For each food item, please give me your best guess as to whether you ATE the food, you're not sure but you LIKELY ATE the food, you're not sure but you LIKELY DID NOT EAT the food, or you DID NOT EAT the food.

MEATS: In the 4 week period, did you eat any of the following COLD CUT, DELI MEAT, OR LUNCHEON MEAT items?

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Ham	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Bologna	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Turkey breast	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Other turkey deli meat (e.g. turkey ham)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

Listeria Case Form

Patient State Laboratory ID No. _____

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Chicken deli meat <i>(NOT fresh chicken or rotisserie chicken)</i>	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Pastrami/ Corned beef	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Other deli/ luncheon meat <i>(specify)</i> _____ _____	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Patè or meat spread that was not canned	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Hot dogs	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
If Yes, were the hot dogs: <input type="checkbox"/> Heated before consumption <input type="checkbox"/> Not heated before consumption (eaten directly out of package)								

Listeria Case Form

Patient State Laboratory ID No. _____

CHEESES: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you eat any of the following CHEESES?

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Brie	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Feta	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Camembert	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Goat	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Blue or gorgonzola	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

Listeria Case Form

Patient State Laboratory ID No. _____

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Mexican-style cheese (Queso fresco, queso blanco)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Farmer's cheese	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Raw (Unpasteurized milk) cheese	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Other soft white cheese (not cream, cottage, or ricotta – specify)_____	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

READY-TO-EAT SALADS: In the 4 week period, did you eat any of the following ready-to-eat, deli-style salads (that were NOT PREPARED AT HOME)?								
	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	<i>If ate or likely ate, How often?</i>	<i>If ate or likely ate, Where was it purchased? (choose all types that apply)</i>	<i>Name(s) of store/restaurant/venue: (all names that apply)</i>	<i>Types or brands: (all that apply)</i>
Potato salad	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Pasta salad	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Tuna salad	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Bean salad	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Hummus	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

Listeria Case Form

Patient State Laboratory ID No. _____

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Cole slaw	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Seafood salad	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Fruit salad (including pre-cut cubes of a single fruit)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Other ready-to-eat meat, vegetable or fruit salad not made at home (Specify)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

Listeria Case Form

Patient State Laboratory ID No. _____

SEAFOOD: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you eat any of the following ready-to-eat fish or seafood items or fruit items?

	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Precooked shrimp	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Precooked crab (including imitation crab meat)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Smoked or cured fish that was not from a can (e.g. smoked salmon or lox)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

Listeria Case Form

Patient State Laboratory ID No. _____

Fruit: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you eat any of the following fruit items?						
Honeydew melon	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cantaloupe	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Watermelon	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was this item purchased from a deli counter at any of the sites? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Listeria Case Form

Patient State Laboratory ID No. _____

MILK: In the 4 weeks between ____/____/____ (date 4 weeks before) through ____/____/____ (specimen collection/delivery date), did you drink any of the following types of milk?

	Drank (=1)	Likely drank (=2)	Likely did NOT drink (=3)	Did NOT drink (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Whole milk	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was any of this milk unpasteurized (raw)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
2% milk	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was any of this milk unpasteurized (raw)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
1% milk	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was any of this milk unpasteurized (raw)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Skim milk	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was any of this milk unpasteurized (raw)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____
Other milk – chocolate, buttermilk, etc. (Specify) _____ _____	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store _____ <input type="checkbox"/> Deli/small market _____ <input type="checkbox"/> Restaurant _____ <input type="checkbox"/> Other venue _____ <input type="checkbox"/> Don't know _____ Was any of this milk unpasteurized (raw)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	_____	_____

OTHER DAIRY: In the 4 week period, did you eat any of the following other dairy items?								
	Ate (=1)	Likely Ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	If ate or likely ate, How often?	If ate or likely ate, Where was it purchased? (choose all types that apply)	Name(s) of store/restaurant/venue: (all names that apply)	Types or brands: (all that apply)
Butter (<i>not margarine or other butter substitute</i>)	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know	_____	_____
Cream	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know	_____	_____
Ice cream	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know	_____	_____
Sour cream	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know	_____	_____
Yogurt	1	2	3	4	<input type="checkbox"/> ~ 1-2 x/month <input type="checkbox"/> ~ 1x/week <input type="checkbox"/> ~ 2-4x/week <input type="checkbox"/> ~ 5-7x/week <input type="checkbox"/> not sure	<input type="checkbox"/> Grocery store <input type="checkbox"/> Deli/small market <input type="checkbox"/> Restaurant <input type="checkbox"/> Other venue <input type="checkbox"/> Don't know	_____	_____

That is all. Thank you very much!

Patient's name: _____	DOB: ____/____/____	Age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk
Patient's address: _____ _____	Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Phone number: (h) () _____ (w) () _____			

Listeriosis—Supplemental Medical History Form

(Use in addition to *Listeria* Case Form CDC for cases not associated with pregnancy)

PREVIOUS DIAGNOSES							
Have you ever been told or diagnosed by a physician as having any of the following:							
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Chronic Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Stomach Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Organ Transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Cancer (other than skin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Specify _____			
Hypertension/ High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know				
End-Stage Renal Disease/ Chronic Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know				
Do you take steroids every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know				
In the 4 weeks before your illness, were you hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, what dates? From ____/____/____ to ____/____/____							