



State/Local Close Contact ID: \_\_\_\_\_

COVID-19 Contact Interview

Local health departments should submit this report to the regional health department. Regional health departments should fax this report to 512-776-7616.

Instructions: This contact form is for use with COVID-19 investigations necessitating contact investigation or follow-up. However, based on the local situation, available resources, and competing priorities, LHDs and PHRs may prioritize contact investigations to focus on exposures to populations at higher risk for severe illness. In some circumstances, LHDs and PHRs may consider suspending contact investigations altogether. Prior to interview with contact, please note the following information about the confirmed case that identified this contact:

Confirmed Case Last: \_\_\_\_\_ First: \_\_\_\_\_
NNDSS local record ID/Case ID for Confirmed Case \_\_\_\_\_
Date of symptom onset: \_\_\_\_\_ (MM/DD/YYYY) [ ] Asymptomatic
Date of last symptom: \_\_\_\_\_ (MM/DD/YYYY) [ ] Still symptomatic
Date of contact's last exposure to confirmed case \_\_\_\_\_ (MM/DD/YYYY)
[ ] Continued exposure

Interviewer information

Date interview completed: \_\_\_\_\_ (MM/DD/YYYY) Interviewer telephone: \_\_\_\_\_
Interviewer Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Organization/affiliation: \_\_\_\_\_
Who is providing information for this form?
[ ] Contact [ ] Parent/guardian
[ ] Other, specify name: \_\_\_\_\_ Relationship to contact: \_\_\_\_\_
Contact's primary language: \_\_\_\_\_ Was this form administered via a translator? [ ] Yes [ ] No

Close contact's information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_
Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Is address the same as the case? [ ] Yes [ ] No

Close contact's demographic information

- 1. Date of birth: \_\_\_\_\_ (MM/DD/YYYY) 2. Age: \_\_\_\_\_ [ ] years [ ] month [ ] days
3. Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Not Specified
4. Race: [ ] White [ ] Asian [ ] American Indian/Alaska Native [ ] Black [ ] Native Hawaiian/Other Pacific Islander
[ ] Other, specify: \_\_\_\_\_ [ ] Unknown
5. Sex: [ ] Male [ ] Female [ ] Unknown [ ] Other

### Symptoms

6. Since your date of last exposure to the confirmed case, have you experienced any of the following symptoms?  No symptoms

Symptom	Symptom Present?			Date of Onset (MM/DD/YYYY)	Date Resolved	Not Resolved
	Yes	No	Unk			
Fever >100.0°F (37.8°C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Subjective fever (felt feverish)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Muscle aches (myalgia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Runny nose (rhinorrhea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Shortness of breath (dyspnea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
New olfactory and taste disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

### Past Medical History

7. Do you have any pre-existing medical conditions?  Yes  No  Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Chronic Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Chronic Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Immunocompromised Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Neurologic/neurodevelopmental disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Specify:
Other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Specify:
If female, pregnant or ≤2 weeks postpartum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	
Current smoker, including vaping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Specify:
Former smoker, including vaping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Specify:

Exposures to confirmed case

8. What is your relationship to the confirmed case? (select all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Spouse/Partner | <input type="checkbox"/> Healthcare Worker      |
| <input type="checkbox"/> Child          | <input type="checkbox"/> Co-worker              |
| <input type="checkbox"/> Parent         | <input type="checkbox"/> Classmate              |
| <input type="checkbox"/> Other Family   | <input type="checkbox"/> Roommate               |
| <input type="checkbox"/> Friend         | <input type="checkbox"/> Other (specify): _____ |

9. Where were you exposed to the confirmed case? (select all that apply)

- |                                    |   |                                    |
|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Household | <input type="checkbox"/> Healthcare setting | <input type="checkbox"/> Work      |
| <input type="checkbox"/> Daycare   | <input type="checkbox"/> School/University  | <input type="checkbox"/> Transit   |
| <input type="checkbox"/> Rideshare | <input type="checkbox"/> Hotel              | <input type="checkbox"/> Community |
| <input type="checkbox"/> Other     |   |                                    |

Specify Location(s) (Name and Address):

10. During the period of **potential exposure** (defined as *two days before* the confirmed case's date of symptom onset through your date of last contact with the confirmed case), did/were you.....?

Exposure	Answer	Start date (date exposure first occurred) (MM/DD/YYYY)	End date (date exposure last occurred) (MM/DD/YYYY)	Number of occurrences (number of times the exposure occurred)	Total cumulative duration of occurrence(s) (specify unit)
...have face to face contact with the confirmed case?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				_____ <input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
...have direct physical contact with the confirmed case? (e.g., hug, shake hands, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				_____ <input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
...physically within 6 feet of the confirmed case?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				_____ <input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days

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Exposure	Answer	Start date (date exposure first occurred) (MM/DD/YYYY)	End date (date exposure last occurred) (MM/DD/YYYY)	Number of occurrences (number of times the exposure occurred)	Total cumulative duration of occurrence(s) (specify unit)
...within 6 feet while the confirmed case was coughing or sneezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
...take an object handed from or handled by the confirmed case? (e.g., pen, paper, food, utensil, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
...in the same room as the confirmed case?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
...sleep in the same room as the confirmed case during the time he/she was ill?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
... share a bathroom with the confirmed case during the time he/she was ill?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
... prepare food with the confirmed case during the time he/she was ill?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days
...travel in the same vehicle (car, bus, airplane), sitting within 6 feet of the confirmed case?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				<input type="checkbox"/> minutes <input type="checkbox"/> hours <input type="checkbox"/> days

A calendar has been provided to use as a memory aid to identify times/places that the case and contact interacted.

# 2020

## JANUARY

Su	Mo	Tu	We	Th	Fr	Sa
			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	31	

## FEBRUARY

Su	Mo	Tu	We	Th	Fr	Sa
						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

## MARCH

Su	Mo	Tu	We	Th	Fr	Sa
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	31				

## APRIL

Su	Mo	Tu	We	Th	Fr	Sa
			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		

## MAY

Su	Mo	Tu	We	Th	Fr	Sa
					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
31						

## JUNE

Su	Mo	Tu	We	Th	Fr	Sa
	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				

## JULY

Su	Mo	Tu	We	Th	Fr	Sa
			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	31	

## AUGUST

Su	Mo	Tu	We	Th	Fr	Sa
						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	31					

## SEPTEMBER

Su	Mo	Tu	We	Th	Fr	Sa
		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			

## OCTOBER

Su	Mo	Tu	We	Th	Fr	Sa
				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	31

## NOVEMBER

Su	Mo	Tu	We	Th	Fr	Sa
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					

## DECEMBER

Su	Mo	Tu	We	Th	Fr	Sa
		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	31		