4018

Blood Systems Research Institute
West Nile Virus Initial Questionnaire (Questionnaire A)

Index Donation Number: | | | | | | | | | | | | | | |

Donor Id Number: | | | | | | | | | | | | | | |

Date of Index Donation (MM / DD / YYYY): | | / | | / | | | | |

Blood Center: | | | | | | | | | | | | | | |

A. Donor located for interview, if not select reason: Donor Located ○ Refused ○ Unable to Locate ○ Died ○ Other: ○

If OTHER please specify:_____

B. Date of Interview (MM / DD / YYYY): | | / | | / | | | | |

C. Donor Properly Identified: Yes ○ No ○ D. Interviewer initials: | | |

Notes to interviewer:
*1. Complete this survey **AS EARLY AS POSSIBLE** after the date of the index donation.*
*2. **Complete Part II (Pages 7-8) of survey before contacting donor for interview. IF donor consents to interview (below) complete Part I (pages 1-6).(For Part II, If information is not complete in the donor record, please complete by asking donor at the time of interview.)***
3. Write the day and date of the index donation in the blanks preceding questions 5 and 12 before you begin the interview.
4. Identify donor by name, date of birth, or social security number.

Read:
We are asking you to be part of an investigation about West Nile virus infection in blood donors. Blood Systems Research Institute, in association with your local blood center, is in charge of this investigation. We are contacting you because a test has shown that you probably had West Nile virus the last time you donated blood. We want to study how you caught the virus and whether you have or had symptoms of West Nile virus infection. If you agree to participate, then I will ask you some questions about your medical history. The interview should only take about 15 minutes. We will keep your personal information confidential to the extent possible by law. Your participation is voluntary. You may refuse to answer any of the questions. If you have questions, you may ask me now. You may also call _____at your blood center at _____ or Dr. Hany Kamel at Blood Systems headquarters at 480-675-5659. Do you have any questions for me before we begin?

1. Do you agree to participate in this investigation? Yes ○ No ○ **If YES**, verbal consent obtained.

Signature of Medical Affairs staff:_____ Date:_____
Interviewer:
If **NO***, then stop the interview.*
If **YES***, then continue with the survey on next page and* **complete all pages 1 through 8.**

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PART I Donor Reported Medical History

Read:
I am going to ask you some questions about whether you got sick around the time of your blood donation. If you have a calendar available, it may help you answer the questions more accurately. Do you have a calendar?

2. What is your **county** of residence? [ ]
*Note to Interviewer: Be sure to record **county** of residence so that we can relate information to CDC WNV databases. Zip code is not sufficient*

3. How many years have you lived at your current address? [ ] years Don't Know ○ Refused ○

4. What is your occupation? ***Interviewer write in response and then select closest match from list below:***

Occupation: [ ]

- ○ Business management or professional service
- ○ Farming, fishing, or forestry
- ○ Sales or office administration
- ○ Construction, building, or grounds maintenance
- ○ Health care services or support
- ○ Military service
- ○ Food preparation or restaurant industry
- ○ Transportation or material transport
- ○ Education or teaching
- ○ Other: _____

You donated blood on (MM / DD / YYYY): [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

In the week before your donation, did you have any of the following symptoms?

5. Fever
Yes ○ No ○ Don't Know ○ Refused ○

If YES to 5: Yes No
5a. Was your temperature measured with a thermometer? ○ ○

If YES to 5a:
5b. What was the highest measured temperature? Don't Remember ○
[ ][ ][ ] . [ ] degrees F or [ ][ ] . [ ] degrees C

6. Headache
Yes ○ No ○ Don't Know ○ Refused ○

7. Eye Pain
Yes ○ No ○ Don't Know ○ Refused ○

8. Body aches (including stiff neck or neck pain)
Yes ○ No ○ Don't Know ○ Refused ○

9. New skin rash
Yes ○ No ○ Don't Know ○ Refused ○

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10. Swollen lymph nodes

Yes ○ No ○ Don't Know ○ Refused ○

11. Nausea or vomiting

Yes ○ No ○ Don't Know ○ Refused ○

12. Muscle weakness

Yes ○ No ○ Don't Know ○ Refused ○

13. Confusion

Yes ○ No ○ Don't Know ○ Refused ○

14. Disorientation

Yes ○ No ○ Don't Know ○ Refused ○

15. Memory problems

Yes ○ No ○ Don't Know ○ Refused ○

16. **In the week before your donation**, did you develop any other symptoms?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, What other symptoms?

16a. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

16b. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

You donated blood on (MM / DD / YYYY): [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

On the day that you donated blood, after your donation did you have any of the following symptoms?

17. Fever

Yes ○ No ○ Don't Know ○ Refused ○

If YES to 17: Yes No

17a. Was your temperature measured with a thermometer? ○ ○

If YES to 17a:

17b. What was the highest measured temperature?

[ ][ ][ ] . [ ] degrees F or [ ][ ] . [ ] degrees C Don't Remember ○

18. Headache

Yes ○ No ○ Don't Know ○ Refused ○

19. Eye Pain

Yes ○ No ○ Don't Know ○ Refused ○

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20. Body aches (including stiff neck or neck pain)

Yes ○ No ○ Don't Know ○ Refused ○

21. New skin rash

Yes ○ No ○ Don't Know ○ Refused ○

22. Swollen lymph nodes

Yes ○ No ○ Don't Know ○ Refused ○

23. Nausea or vomiting

Yes ○ No ○ Don't Know ○ Refused ○

24. Muscle weakness

Yes ○ No ○ Don't Know ○ Refused ○

25. Confusion

Yes ○ No ○ Don't Know ○ Refused ○

26. Disorientation

Yes ○ No ○ Don't Know ○ Refused ○

27. Memory problems

Yes ○ No ○ Don't Know ○ Refused ○

28. **On the day that you donated blood**, after your donation did you develop any other symptoms?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, What other symptoms?

28a. | | | | | | | | | | | | | | | |

28b. | | | | | | | | | | | | | | | |

We want to know if West Nile Virus is more dangerous for people with certain medical conditions.

Has your doctor previously diagnosed you as having any of the following conditions ?

29. High blood pressure

Yes ○ No ○ Don't Know ○ Refused ○

30. Diabetes

Yes ○ No ○ Don't Know ○ Refused ○

31. Heart disease

Yes ○ No ○ Don't Know ○ Refused ○

32. Previous seizures

Yes ○ No ○ Don't Know ○ Refused ○

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33. Previous stroke

Yes ○ No ○ Don't Know ○ Refused ○

34. Previous meningitis (inflammation of the lining of the brain or spinal cord)

Yes ○ No ○ Don't Know ○ Refused ○

35. Previous encephalitis (inflammation or infection of the brain)

Yes ○ No ○ Don't Know ○ Refused ○

36. At the time that you donated blood, were you taking any medications?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, what medications were you taking?

36a. | | | | | | | | | | | | | | |

36b. | | | | | | | | | | | | | | |

36c. | | | | | | | | | | | | | | |

36d. | | | | | | | | | | | | | | |

37. At time you donated blood, were you a cigarette smoker?

Yes ○ No ○ Don't Know ○ Refused ○

IF YES, On average how many cigarettes do you smoke in one day?

37a. | | | cigarettes per day Don't Know ○ Refused ○

Now we would like to ask about some of your PAST medical history.

Have you ever been diagnosed by a doctor with any of the following diseases?

38. Any previous illness due to West Nile virus infection:

Yes ○ What Year? | | | | | No ○ Don't Know ○ Refused ○

39. St. Louis encephalitis:

Yes ○ What Year? | | | | | No ○ Don't Know ○ Refused ○

40. Dengue ("deng gee") fever:

Yes ○ What Year? | | | | | No ○ Don't Know ○ Refused ○

41. Japanese encephalitis:

Yes ○ What Year? | | | | | No ○ Don't Know ○ Refused ○

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Have you ever been vaccinated against any of the following diseases?

42. Yellow fever:

Yes ○ What Year? [ ][ ][ ][ ] No ○ Don't Know ○ Refused ○

43. Japanese encephalitis:

Yes ○ What Year? [ ][ ][ ][ ] No ○ Don't Know ○ Refused ○

44. Tick-borne encephalitis:

Yes ○ What Year? [ ][ ][ ][ ] No ○ Don't Know ○ Refused ○

45. Have you ever served in the military?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, please provide the dates and locations of service.

45a. Entered military service (MM / DD / YYYY): [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

45b. Left military service (MM / DD / YYYY): [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Where were you stationed?

45c. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

45d. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

45e. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

46. Have you traveled outside your current state of residence in the last 3 weeks?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, please list all of the states you have traveled in:

46a. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

46b. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

46c. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

46d. [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

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PART II Index Donation Record

47. In the past 5 years, have you traveled to or lived in a country outside of the United States?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, please list all of the countries you have traveled or lived in and the dates you were there starting with the most recent and working backward:

47a. Country: | | | | | | | | | | | | | Dates in country: _____

47b. Country: | | | | | | | | | | | | | Dates in country: _____

47c. Country: | | | | | | | | | | | | | Dates in country: _____

47d. Country: | | | | | | | | | | | | | Dates in country: _____

47e. Country: | | | | | | | | | | | | | Dates in country: _____

Interviewer if the next section was completed using the index donation record, **Please Read:** This concludes the survey today. Thank you very much for your participation. We will contact you in a few weeks for follow-up surveys.

Interviewer or Blood Center Staff:
1. Complete this part of the survey for all donors whether they have participated in the survey or not.
*2. Obtain the information from the Donation Records of the Blood Center. (IF Information is not complete in the donor record **and** donor consents to be interviewed, please complete by asking donor at the time of interview.)*

48. Index donation phlebotomy type (enter letter code from record): | |

Donor Demographics

49. Zip code of donor's residence on date of index donation: | | | | | |

50. Donor initials: | | | |

51. Date of birth: (MM / DD / YYYY) | | / | | / | | | | |

52. Gender: Male ○ Female ○

53. Race:

- ○ White or Caucasian
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ American Indian or Native Alaskan
- ○ Other:_____
- ○ Don't Know
- ○ Refused

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54. Ethnicity

Hispanic or Latino ○ **NOT** Hispanic or Latino ○ Don't Know ○ Refused ○

55. Educational attainment:

○ 8th Grade or Less

○ Some High School but **NO** Diploma

○ High school graduate (for example, Diploma or GED)

○ Some College or Technical School

○ Bachelor Degree (for example, BA, BS, or AB)

○ Master or Professional Degree (for example, MA, MS, MD, PhD, or JD)

Physical Findings

56. Donor temperature? ☐☐☐.☐ degrees F or ☐☐.☐ degrees C

57. Pulse? ☐☐

58. Blood pressure? ☐☐☐ systolic / ☐☐☐ diastolic

Responses to Health History Questionnaire

	Yes	No
59. Feeling well and health today:	○	○
60. Fever with headache in past 7 days:	○	○
61. Pills or medications in past 4 weeks:	○	○
62. Shots or vaccinations in past 4 weeks:	○	○

If YES, which shots or vaccinations:

62a. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

62b. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

62c. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

62d. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Interviewer, if the previous section was completed at the time of interview, **Please Read:** This concludes the survey today. Thank you very much for your participation. We will contact you in a few weeks for follow-up surveys.

End of Questionnaire

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Blood Systems Research Institute
West Nile Virus Follow-up Questionnaire (Questionnaire B)

Index Donation Number: | | | | | | | | | | | | | | | |

Donor ID Number: | | | | | | | | | | | | | | | |

Date of Index Donation (MM / DD / YYYY): | | | / | | | / | | | | |

Blood Center: | | | | | | | | | | | | | | | |

A. Donor located for interview, if not select reason: Donor Located ○ Refused ○ Unable to Locate ○ Died ○ Other: ○

If OTHER please specify:_____

B. Date of Interview (MM / DD / YYYY): | | / | | / | | | | |

C. Donor Properly Identified: Yes ○ No ○

D. Interviewer initials: | | | |

Note to interviewer:
*1. Complete this survey **AT LEAST 14 DAYS AFTER** the date of the index donation*
2. Write the day and date of the index donation in the blanks preceding question 2 before you begin the interview.
3. Identify donor by name, date of birth, or social security number

Read:
We are asking you to be part of an investigation about West Nile virus infection in blood donors. Blood Systems Research Institute, in association with your local blood center, is in charge of this investigation. We are contacting you because a test has shown that you probably had West Nile virus the last time you donated blood. We want to study how you caught the virus and whether you have or had symptoms of West Nile virus infection. If you agree to participate, then I will ask you some questions about your medical history. The interview should only take about 5-10 minutes. We will keep your personal information confidential to the extent possible by law. Your participation is voluntary. You may refuse to answer any of the questions. If you have questions, you may ask me now. You may also call _____at your blood center at _____ or Dr. Hany Kamel at Blood Systems headquarters at 480-675-5659. Do you have any questions for me before we begin?

1. Do you agree to participate in this investigation? Yes ○ No ○ **If YES**, verbal consent obtained.

Signature of Medical Affairs staff:_____ Date:_____

Interviewer:
If **NO***, then stop the interview***.**
If **YES***, then continue with the survey on next page and complete all pages***.**

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West Nile Virus Follow-up Questionnaire (Questionnaire B)

Read:

I am going to ask you some questions about whether you got sick in the 14 days after your blood donation. If you have a calendar available, it may help you answer the questions more accurately. Do you have a calendar?

You donated blood on (MM / DD / YYYY): ☐☐ / ☐☐ / ☐☐☐☐

In the 14 days after your donation, did you have any of the following symptoms?

2. Fever

Yes ○ No ○ Don't Know ○ Refused ○

If YES to 2: Yes No

2a. Was your temperature measured with a thermometer? ○ ○

If YES to 2a:

2b. What was the highest measured temperature?

☐☐☐.☐ degrees F or ☐☐.☐ degrees C Don't Remember ○

3. Headache

Yes ○ No ○ Don't Know ○ Refused ○

4. Eye Pain

Yes ○ No ○ Don't Know ○ Refused ○

5. Body aches (including stiff neck or neck pain)

Yes ○ No ○ Don't Know ○ Refused ○

6. New skin rash

Yes ○ No ○ Don't Know ○ Refused ○

7. Swollen lymph nodes

Yes ○ No ○ Don't Know ○ Refused ○

8. Nausea or vomiting

Yes ○ No ○ Don't Know ○ Refused ○

9. Muscle weakness

Yes ○ No ○ Don't Know ○ Refused ○

10. Confusion

Yes ○ No ○ Don't Know ○ Refused ○

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West Nile Virus Follow-up Questionnaire (Questionnaire B) Page 3 of 4

11. Disorientation

Yes ○ No ○ Don't Know ○ Refused ○

12. Memory problems

Yes ○ No ○ Don't Know ○ Refused ○

13. **In the 14 days after your donation**, did you develop any other symptoms?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, What other symptoms?

13a. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

13b. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

13c. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

13d. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Interviewer:
*1. If the respondent answered **NO** to every Symptom Question 2 through 13, **then stop and conclude the interview by reading the text in the middle of Page 4.***

*2. If the respondent answered **YES** to **ANY** Symptom Question 2 through 13, **then continue with Questions 14 through 19.***

14. What was the date of onset of your illness? (MM / DD / YYYY)

☐☐ / ☐☐ / ☐☐☐☐ Don't Know ○ Refused ○

If respondent answered Don't Know:

14a. How many days after donation did you get sick? ☐☐ days Don't Know ○ Refused ○

15. What was the date of resolution of your illness or symptom(s)? (MM / DD / YYYY)

☐☐ / ☐☐ / ☐☐☐☐ Not Yet Resolved ○ Don't Know ○ Refused ○

16. Did you go to a doctor or clinic for this illness?

Yes ○ No ○ Don't Know ○ Refused ○

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West Nile Virus Follow-up Questionnaire (Questionnaire B) Page 4 of 4

17. Did you spend at least one night in the hospital because of this illness?

Yes ○ No ○ Don't Know ○ Refused ○

If YES, 17a. What was the date of your admission to the hospital? (MM / DD / YYYY)

☐☐ / ☐☐ / ☐☐☐☐ Don't Know ○ Refused ○

18. Did your doctor or other health care professional tell you had West Nile fever?

Yes ○ No ○ Don't Know ○ Refused ○

19. Did your doctor or other health care professional tell you had West Nile meningitis or encephalitis?

Yes ○ No ○ Don't Know ○ Refused ○

Read:
This concludes this survey. You may be contacted in a few months for a final follow-up survey.

End of questionnaire