**INTERVIEW**

EpiTrax # ____________  
Interviewer Name: ________________

Number of Call Attempts: _______  
Follow-up Status:  ☐ Interviewed  ☐ Refused Interview  ☐ Lost to Follow-Up*

Date of Interview (must enter MM/DD/YYYY): ________________  
*At least three attempts at different times of the day should be made before considered lost to follow-up.

Respondent was:  ☐ Self  ☐ Parent  ☐ Spouse  ☐ Other, Specify: ____________________________

**DEMOGRAPHICS**

County: ____________  
Birth gender:  ☐ Male  ☐ Female  
Date of Birth: ________________  
Age: ______

Hispanic/Latino origin:  ☐ Yes  ☐ No  ☐ Unknown

Race:  ☐ White  ☐ Black/African American  ☐ American Indian/Alaska Native  ☐ Asian  
☐ Native Hawaiian/Other Pacific Islander  ☐ Other__________________  ☐ Unknown

**CLINICAL**

Were you hospitalized?  ☐ Yes  ☐ No  ☐ Unknown  
Hospital Name: ____________________________

Total Days Hospitalized: _______  
Admit Date: ________________  
Discharge Date: ________________

Died?  ☐ Yes  ☐ No  ☐ Unknown  
If Yes, Date of death: __________________

Are you pregnant?  ☐ Yes  ☐ No  ☐ Unknown  
If Yes, Expected delivery date: __________________

**EPIDEMIOLOGICAL**

Occupation: ____________________________

<table>
<thead>
<tr>
<th>Health care worker?</th>
<th>☐ Yes  ☐ No  ☐ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group living?</td>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td>Day care association?</td>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td>School association?</td>
<td>☐ Yes  ☐ No  ☐ Unknown</td>
</tr>
<tr>
<td>If yes, type of association</td>
<td>☐ Student  ☐ Teacher  ☐ Other</td>
</tr>
</tbody>
</table>

For school association, record details on teacher or grade:
If yes to any, list details for each:

<table>
<thead>
<tr>
<th>Facility Name(s):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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</table>

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<thead>
<tr>
<th>Address(es):</th>
<th></th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Phone Number(s):</th>
<th></th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Imported from:

- [ ] Indigenous  
- [ ] Outside U.S.  
- [ ] Outside of County  
- [ ] Out of State  
- [ ] Unknown

**INVESTIGATION**

### A. Symptoms & Signs

- **Rash?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **Rash location:**
  - [ ] Generalized  
  - [ ] Focal  
  - [ ] Unknown

- **If “Generalized,” locations (mark all that apply):**
  - [ ] Face/head  
  - [ ] Arms  
  - [ ] Legs  
  - [ ] Trunk  
  - [ ] Inside mouth  
  - [ ] Other (specify) ____________

- **Total number of lesions:**
  - [ ] < 50 lesions  
  - [ ] 50-249 lesions  
  - [ ] 250-500 lesions  
  - [ ] > 500 lesions

- **Is the character of lesions (all categories—1 to >500) known?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, mostly macular/popular?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, mostly vesicular?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, Hemorrhagic?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, Itchy?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, Scabs?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, Crops/waves?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, Did the rash crust?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **If yes, How many days until all the lesions crusted over?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **Fever?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

- **Date of fever onset:**
  - ____________

- **If yes, highest measured temperature (F)?**
  - ____________

- **Total number of days with fever:**
  - ____________ days

- **Immunocompromised?**
  - [ ] Yes  
  - [ ] No  
  - [ ] Unknown

  If yes, specify: ____________
B. Complications

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you visit a healthcare provider during this illness?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>Did you develop any complications that were diagnosed by a healthcare provider?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ If yes, skin/soft tissue infections?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ Cerebellitis/Ataxia?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ If yes specify:</td>
<td></td>
</tr>
<tr>
<td>▪ Encephalitis?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ Dehydration?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ Hemorrhagic condition?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ Pneumonia?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>▪ If yes, how diagnosed?</td>
<td>□ X-rays □ Provider □ Unknown</td>
</tr>
<tr>
<td>▪ Other complications?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
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<td></td>
<td>If yes, specify: ___________________________</td>
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</tbody>
</table>

C. Vaccination History

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive varicella-containing vaccine?</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
<tr>
<td>Number of doses received ON or AFTER 1st birthday:</td>
<td></td>
</tr>
<tr>
<td>If &gt;=6 years old and received one dose on or after 6th birthday but never received second dose, what is the reason?</td>
<td>□ Born outside the United States □ Laboratory confirmation of previous disease □ MD diagnosis of previous disease □ Medical contraindication □ Never offered vaccine □ Parental/patient forgot to vaccinate □ Parental/patient refusal □ Parent/patient report of previous disease □ Philosophical exemption □ Unknown □ Other, specify:</td>
</tr>
</tbody>
</table>

D. Vaccination Record

<table>
<thead>
<tr>
<th>Vaccine #</th>
<th>Vaccination Date</th>
<th>Vaccine Type</th>
<th>Manufacturer</th>
<th>Lot Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</table>
### E. Exposure—Risk Factors

<table>
<thead>
<tr>
<th>Where were you born (country)?</th>
<th></th>
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<tbody>
<tr>
<td>If not born in the U.S., how many years have you lived in the U.S.?</td>
<td></td>
</tr>
<tr>
<td>Prior to onset of rash, was this case epi-linked to another confirmed or probable case?</td>
<td>☐ Yes ☐ No ☐ Unknown</td>
</tr>
<tr>
<td>If yes, epi-linked to:</td>
<td>☐ Confirmed varicella case ☐ Probable varicella case ☐ Herpes zoster case</td>
</tr>
<tr>
<td>Transmission setting (setting of exposure)</td>
<td>☐ Athletics ☐ College ☐ Community ☐ Correctional facility ☐ Day Care ☐ Doctor’s Office ☐ Home ☐ Hospital ER ☐ Hospital Ward ☐ Hospital Outpatient Clinic ☐ International Travel ☐ Military ☐ Place of worship ☐ School ☐ Work ☐ Unknown ☐ Other, specify:</td>
</tr>
</tbody>
</table>