MRCE-CWRU-DVBND RVF surveys: Part 1, PERSONAL DETAILS

ID

Date of Registration (dd/mm/yyyy)

Subject's First Name

Second Name

Third Name

Other name

House Number

Village

Head of Household's Name

Relationship to HH

Usual Occupation

Did you SLEEP in this house LAST NIGHT? ○ Yes ○ No

Year of Birth

Sex (F=Female, M=Male)

How many YEARS living here?:

Stay how many MONTHS next year?

Father's name:

Mother's name:

Is father living? ○ Yes ○ No ○ Don't Know

Is mother living? ○ Yes ○ No ○ Don't Know

Where does he live?

Where does she live?

F's father:

M's father:

F's mother:

M's mother:

Demography team to check village records and complete boxes below:

F study number:

M study number:

F house number:

M house number:

Name of Data Collector

Name of Data Enterer

Principal Investigators: LaBeaud, Kazura, King, Muchiri

MRCE-CWRU-DVBND RVF surveys: Part 2, NON-ANIMAL EXPOSURES

ID _____ IF NOT HOUSEHOLD INFORMANT, skip this page, go to Part 3

Has your home been flooded in past 4 yrs? ○ Yes ○ No

If yes, when was it flooded? (year) _____

Have you ever been displaced by floods? ○ Yes ○ No

If yes, when were you displaced? (year) _____

Do you get mosquito bites frequently? ○ Yes ○ No

Do you avoid mosquito bites? ○ Yes ○ No

IF NO, skip to Part B, below

Do you sleep under a mosquito net? ○ Yes ○ No

Do you use mosquito coil? ○ Yes ○ No

If yes, how often do you use coils? _____

Indicate: Never, Other, Monthly, Weekly, or Daily

Do you use other mosquito control? ○ Yes ○ No

If yes, what kind? _____

Do you have screens on your home windows? ○ Yes ○ No

Part B:

Do you get mosquito bites during the daytime? ○ Yes ○ No

Do you get mosquito bites during the nighttime? ○ Yes ○ No

When was the last time you felt unwell? _____

Indicate: < 1month, 1-3 mo, 4-6mo, 7-12mo, 1-2 yr, or never

Have you had a death in the family in last 4 yrs? ○ Yes ○ No

If yes, how many?: _____

If yes, when?: _____

Notes: _____

What is your source of drinking water? Mark all that apply.

River	○ Yes ○ No	Inside water container	○ Yes ○ No
Pond or Pool	○ Yes ○ No	Kiosk or Tanker	○ Yes ○ No
Rain or cistern	○ Yes ○ No	Water tap/piped	○ Yes ○ No
Public well/borehole	○ Yes ○ No	Other	○ Yes ○ No

Interviewer: note type of roofing.

Indicate: natural material, corrugated metal or plastic, or other

Interviewer: note type of latrine.

Indicate: bush, pit, VIP latrine, toilet, other

Interviewer: note type of flooring.

Indicate: dirt, wood, cement, tile, or other

List objects around home that collect water [tires, pots, plants,etc.]

MRCE-CWRU-DVBND RVF surveys: Part 3, ANIMAL EXPOSURES

ID

How often do you have sheep contact?:

Indicate: Never, Other, Monthly, Weekly, or Daily

How often do you have goat contact?:

Indicate: Never, Other, Monthly, Weekly, or Daily

How often do you have cow contact?:

Indicate: Never, Other, Monthly, Weekly, or Daily

How often do you have camel contact?:

Indicate: Never, Other, Monthly, Weekly, or Daily

Have you SHELTERED livestock in your home? ○ Yes ○ No

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Do you SLAUGHTER livestock? ○ Yes ○ No

If yes, when was the last time?

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Do you SKIN or BUTCHER livestock? ○ Yes ○ No

If yes, when was the last time?

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Do you eat RAW MEAT? ○ Yes ○ No

Do you HANDLE RAW MEAT in cooking? ○ Yes ○ No

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Have you ever MILKED an animal? ○ Yes ○ No

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Have you ever DRUNK RAW MILK? ○ Yes ○ No

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Do you ASSIST DURING the birth of livestock? ○ Yes ○ No

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

Have you DISPOSED OF AN ABORTED ANIMAL FETUS? ○ Yes ○ No

camel ☐ sheep ☐ goat ☐ cow ☐ other ☐

MRCE-CWRU-DVBND RVF surveys: Part 4, PATIENT SYMPTOMS

ID

Are you sick now? ○ Yes ○ No

How long have you been sick?:

Have you had any of these symptoms in the LAST 30 DAYS?

Fever	○ Yes ○ No	No appetite	○ Yes ○ No
Backache	○ Yes ○ No	Vomiting	○ Yes ○ No
Nausea	○ Yes ○ No	Malaise	○ Yes ○ No

Have you EVER had any of these symptoms?

Vomiting Blood	○ Yes ○ No	Severe bruising for no reason	○ Yes ○ No
Red eyes	○ Yes ○ No	Gum bleeding	○ Yes ○ No
Poor vision	○ Yes ○ No	Painful eyes to light	○ Yes ○ No
Eye pain	○ Yes ○ No		
Spinning feeling because of an illness	○ Yes ○ No	Mental Confusion because of an illness	○ Yes ○ No
Much too sleepy because of an illness	○ Yes ○ No	Severe neck stiffness	○ Yes ○ No
Coma	○ Yes ○ No	Seizures or Fits	○ Yes ○ No

Principal Investigators: LaBeaud, Kazura, King, Muchiri

MRCE-CWRU-DVBND RVF surveys: Part 5, PHYSICAL EXAM

ID | Weight in kg | Height in cm

Wasted? ○ Yes ○ No

Scleral Hemmorhages? ○ Yes ○ No

Scleral Icterus? ○ Yes ○ No

Jaundice? ○ Yes ○ No

Petechiae? ○ Yes ○ No

Liver Enlarged? ○ Yes ○ No

Spleen Enlarged? ○ Yes ○ No

Lymphadenopathy

Comments

Name of Medical Doctor

Name of Data Enterer

Principal Investigators: LaBeaud, Kazura, King, Muchiri

MRCE-CWRU-DVBND RVF surveys: Part 6, OPHTHALMOLOGIC EXAM

ID

Visual Acuity-L

Visual Acuity-R

Anterior Chamber-L

Anterior Chamber-R

Anterior Uveitis-L? ○ Yes ○ No

Anterior Uveitis-R? ○ Yes ○ No

Posterior Chamber-L

Posterior Chamber-R

Vitreous reaction-L? ○ Yes ○ No

Vitreous reaction-R? ○ Yes ○ No

Retina-L

Retina-R

Retinitis-L? ○ Yes ○ No

Retinitis-R? ○ Yes ○ No

Macular-L? ○ Yes ○ No

Macular-R? ○ Yes ○ No

Paramacular-L? ○ Yes ○ No

Paramacular-R? ○ Yes ○ No

Retinal Hemorrhage-L? ○ Yes ○ No

Retinal Hemorrhage-R? ○ Yes ○ No

Zone-L

Zone-R

Area-L

Area-R

Optic disc edema-L? ○ Yes ○ No

Retinal vasculitis-L? ○ Yes ○ No

Optic disc edema-R? ○ Yes ○ No

Retinal vasculitis-R? ○ Yes ○ No

Comments: (Is this RVF-related or Other?)

Ophthalmologist Name

Data Enterer Name