

e-Questionnaire. Questionnaire for Gastroenteritis Investigation

Interviewer: _____

Interview Date: ____/____/____

Hospital ID: _____

Basic Information

1. Name: _____

2. Sex: male female

3. Birth date: ____ year ____ month ____ day

4. Education: illiterate grade 1-6 grade 7-12 grade 13-16
college/university graduate

5. Are you a student? yes no

If your answer is “yes,” what is the name of your school?

6. What is your occupation? _____

7. Address: _____ County/City: _____ Village/Town/District: _____

8. How many rooms are there in your home? _____rooms

9. What is the size of your home? <50 50-80 81-130 131-180 >180 m²

10. When is the best available time to contact you after 1 week?

daytime (8:00 - 17:00) Phone Number: _____

night time (17:00 - 21:00) Phone Number: _____

either day or night (8:00 - 21:00) Phone Number: _____

Medical Condition and Disease History

1. ED date of arrival/time: ____ year ____ month ____ day ____ hour ____ minute

2. Temperature: _____°C Pulse: _____/min Breath: _____/min

3. Blood Pressure: SBP_____/DBP _____ mmHg

4. Do you have any of the following medical conditions? hypertension diabetes mellitus

AIDS liver cirrhosis kidney dialysis pulmonary emphysema

chronic bronchitis asthma post-gastrectomy

taking steroids or immunosuppressants within the past month

receiving chemotherapy within the past month none

5. Have you taken any of the following within one month prior to illness?

antibiotics antacids H₂ antagonists or proton pump inhibitors

colchicine diet pills Traditional Chinese medications Chinese medicinal herbs

modern medicine none

6. Have you had either diarrhea or vomiting symptoms in the past month? yes no

7. Have you previously been administered this questionnaire in the past month? yes no

8. Did you have any of the following symptoms/signs?

- nausea vomiting diarrhea abdominal pain abdominal distention
anorexia weakness sore body tenesmus fever (>38 °C)
chill skin rash headache dizziness convulsion
cough runny nose sore throat difficulty breathing/asthma
others _____
none

(If you chose “none,” please go to the next section – “Contact and Travel History”)

4. When did you begin to have uncomfortable symptoms?
 ____ month ____ day, morning afternoon night, ____ hour ____ minute
5. Which of these uncomfortable symptoms appeared first?
vomiting diarrhea both
6. What is the maximum frequency of diarrhea per day? _____ times/day
7. What is the maximum frequency of vomiting per day? _____ times/day
8. When you experience diarrhea, what does your stool look like?
watery loose stool solid (normal shape)
 Was your stool accompanied by any of the following symptoms?
 blood mucous none
9. Have you had hemorrhoids with bleeding before this attack? yes no
10. When did you have the symptoms indicated above?
 Did you take any medicine without a doctor’s prescription? yes no
 Did you visit a doctor? yes no
 If your answer is “yes,” please give the name of the clinic/hospital:

If you visited a doctor, did the doctor take a stool sample? yes no

Contact and Travel History

1. With whom do you live? family members classmates colleagues friends
alone others (please specify) _____
 If you live with family members, how many individuals are presently living with you? _____
 adults _____ children
2. Have any of your family members, classmates, colleagues, friends, or neighbors had either vomiting or diarrhea symptoms over the past 4 weeks? yes no
 If so, please specify the number of symptoms experienced for each individual

 What was the frequency per day? _____
 How long did the symptoms last? <3 days 4-6 days 1-2 weeks
3. Have you had contact with any children over the past week? yes no
 If your answer is “yes,” do you have vomiting or diarrhea symptoms? yes no
4. Did you travel abroad last month?

no

yes - please specify the country: _____,

When did you start the trip? ___ month ___ day

When did you return from the trip? ___ month ___ day

5. Did you travel locally in the last month?

no

yes - please specify the destination: _____,

When did you start the trip? ___ month ___ day

When did you return from the trip? ___ month ___ day

Specific activities

1. Did you engage in any of following activities?

| Exposure | Within 24 hours before symptoms | 24-72 hours before symptoms | 4-7 days before symptoms |
|--------------------------------|--|--|--|
| Change a diaper | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swimming | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shake hands with others | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Take a bus | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Take an airplane | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Take mass rapid transit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Touch pets or other animals | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Go to the theater/pub | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wash hands before a meal | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wash hands with soap | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hugging or kissing | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dine out | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Attend a banquet | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Attend an open-air banquet | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Did you experience any of the following in the week prior to the onset of symptoms?

See a fly while eating Yes No

See a cockroach while eating Yes No

Restaurant exposure

Did you eat at any of the following types of commercial food establishments?

| Exposure | Within 1 week before symptoms | Exposure | Within 1 week before symptoms |
|--|--|--|--|
| Eat at a noodle shop | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat from a street truck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat at a Japanese restaurant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat at a hamburger fast food restaurant | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat at a Chinese/Western restaurant | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Specific food exposure

1. Did you eat any dishes containing the following foods prior to the onset of symptoms?

| Exposure | Within 24 hours before symptoms | 24-72 hours before symptoms | 4-7 days before symptoms |
|---|--|--|--|
| Eat salad | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat raw oysters | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat raw fish | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat raw eggs | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat over-easy eggs | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat clams/shellfish (other than oysters) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat beef | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat pork | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat fish | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat chicken | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat mutton | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat leftovers | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Did you eat any dish containing the following foods within one week before symptoms?

| Exposure | Within 1 week before symptoms | Exposure | Within 1 week before symptoms |
|-----------------------|--|------------------------|--|
| Eat ice shavings | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat cold side dishes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat flavored popsicle | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat pickled vegetables | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|------------------|--|------------------|--|
| Eat a duck/goose | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat ginger | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat sandwiches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat spring onion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat hamburger | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat cold noodles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat sushi | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat ice cream | <input type="checkbox"/> Yes <input type="checkbox"/> No |

3. Did you eat any of the following fruits?

| Exposure | Within 1 week | | Exposure | Within 1 week | |
|------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| | before symptoms | | | before symptoms | |
| Strawberry | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Guava | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Papaya | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tomato | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Litchi | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grapes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Honey peach | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tangerine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sakya | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orange | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dragon fruit | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Watermelon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kiwi | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Apple | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mango | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Banana | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cantaloupe | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pineapple | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Durian | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pear | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Carrabolla | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Plum | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Grapefruit | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bell apple | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Granadilla | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cherry | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

4. Did you drink any of the following types of juice?

| Exposure | Within 1 week | | Exposure | Within 1 week | |
|------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| | before symptoms | | | before symptoms | |
| Lemon juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Apple juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Guava juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sugar cane juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tomato juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pineapple juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grape juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kiwi juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grapefruit juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mango juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orange juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Papaya juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Watermelon juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mixture of fruit juices | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

5. Did you drink any of the following forms of water or milk?

| Exposure | Within 1 week before symptoms | Exposure | Within 1 week before symptoms |
|-------------------------|--|---|--|
| Drink tap water | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drink raw milk | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drink water from a well | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drink milk tea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drink bottled water | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drink mineral water [non-commercially available] | <input type="checkbox"/> Yes <input type="checkbox"/> No |
