Maryland Department of Health and Mental Hygiene
Epidemiology and Disease Control Program
Revised September, 2000

Respiratory Illness Employee Questionnaire

Please fill out this questionnaire as completely as possible, including negative answers where relevant.

Name of facility:_____

County:_____

Employee name:_____ Sex:_____ Age:_____

Job description:_____

_____

_____

Work areas:_____

Have you had a flu vaccine this season? yes ☐ no☐

Have you had any symptoms of respiratory illness since _____? yes ☐ no☐ If yes,

Date of onset:_____ Duration of symptoms:_____

Did you miss work because of these symptoms? yes ☐ no ☐ Dates:_____ Signs and symptoms:

Fever:	yes ☐	no☐	GI symptoms:	yes ☐	no☐
Highest temp._____			(specify)_____		
Chills:	yes ☐	no☐	Chest congestion:	yes ☐	no☐
Headache:	yes ☐	no☐	Sore throat:	yes ☐	no☐
Muscle aches:	yes ☐	no☐	SOB:	yes ☐	no☐
Cough:	yes ☐	no☐	Nasal congestion:	yes ☐	no☐
Wheezing:	yes ☐	no☐	Other:_____		

Did you consult a physician for these symptoms? yes ☐ no☐ If yes,

What was the physician's diagnosis?_____

What was the prescribed treatment?_____

_____

Did you follow the prescribed treatment? yes ☐ no☐ If no, what treatment did you follow?_____

Today's date:_____

Thank you for your cooperation.

Maryland Department of Health and Mental Hygiene
Epidemiology and Disease Control Program
Revised September, 2000

Respiratory Illness Resident Questionnaire for Pneumonia Outbreaks in Long Term Care Facilities

Name of facility:_____ **Outbreak number:**_____

Form completed by:_____ **Date:**_____

Demographics:

Name:	Sex:	Age:	DOB:
Wing and floor:	Room:	Admitted to facility:	

Vaccination history:

Influenza vaccine:	yes ☐	no ☐	refused ☐	Date:
Pneumococcal vaccine:	yes ☐	no ☐	refused ☐	Date:

Signs and symptoms:

Ill: yes ☐ no ☐	Date of onset:	Duration:
Fever: yes ☐ no ☐ highest temp:_____ Chills: yes ☐ no ☐ Myalgias: yes ☐ no ☐ Headache: yes ☐ no ☐	Cough: yes ☐ no ☐ Nasal congestion: yes ☐ no ☐ Chest congestion: yes ☐ no ☐ Sore throat: yes ☐ no ☐ Wheezing: yes ☐ no ☐	SOB: yes ☐ no ☐ GI symptoms: yes ☐ no ☐ (specify)_____ Other: yes ☐ no ☐ _____

Diagnosis and outcome:

Diagnosis: Pneumonia yes ☐ no ☐ ILI yes ☐ no ☐ URIyes ☐ no ☐ Other:_____	Causative agent:	Physician(s) name & number: _____ _____
Hospitalized: yes ☐ no ☐	Dates:	Hospital name:
Died: yes ☐ no ☐	Date:	Cause of death:

Diagnostics:

Chest X-ray: yes ☐ no ☐	Date:	Result:
Viral throat culture: yes ☐ no ☐	Date:	Result:
Sputum Gram stain: yes ☐ no ☐	Date:	Result:
Bacterial sputum culture: yes ☐ no ☐	Date:	Result:
Blood culture: yes ☐ no ☐	Date:	Result:
Mycoplasma throat culture: yes ☐ no ☐ *Mycoplasma* sputum culture: yes ☐ no ☐	Date:	Result:
Legionella sputum culture: yes ☐ no ☐	Date:	Result:
Legionella antigen (urine): yes ☐ no ☐	Date:	Result:
Acute serum: yes ☐ no ☐	Date:	Result:
Convalescent serum: yes ☐ no ☐	Date:	Result:
Other:	Date:	Result:

If *S. pneumoniae* isolated:

Penicillin sensitive: yes ☐ no ☐	*S. pneumoniae* type:_____	Isolate available: yes ☐ no ☐

Treatment:

Antibiotic	Dosage	Dates

Other treatment:_____

Risk Factors: underlying illnesses, medications, etc.

_____

_____

Comments: