Interviewer Name_____

COVID-19 Investigation Form

Demographic Information:

First Name:

Last Name:

Age:

Date of Birth:

Gender:
- ☐ Male
- ☐ Female

Race:
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Hawaiian or Pacific Islander
- ☐ White
- ☐ Asian
- ☐ Unknown

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Address:

City:

State:

Zip:

County:

Home Phone Number:

Work Phone Number:

Other Phone Number:

Email Address:

Case Name _____

Work or School:

Do you attend or work in a childcare center?

- ☐ No
- ☐ Yes – Childcare Attendee
- ☐ Yes – Staff Member

If you work at or attend a childcare center, what is the name of your childcare facility?

Do you work at or attend a K12 school?

- ☐ No
- ☐ Yes – Childcare Attendee
- ☐ Yes – Staff Member

If you work at or attend a K12 school, what is the name of your K12 school?

Do you work at or attend a community college, college or university?

- ☐ No
- ☐ Yes – Childcare Attendee
- ☐ Yes – Staff Member

If you work at or attend a community college, college or university, what is the name of your community college, college or university?

Do you work at a hospital?

- ☐ No
- ☐ Yes

What is the name of the hospital where you work?

Do you work at a long term care facility?

- ☐ No
- ☐ Yes

What is the name of the long term care facility where you work?

Do you work at an assisted living facility?

- ☐ No
- ☐ Yes

What is the name of the assisted living facility where you work?

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Do you work in a healthcare facility?

- ☐ No
- ☐ Yes

What is the name of the healthcare facility where you work?

Do you reside or work in a correctional facility?

- ☐ No
- ☐ Yes – Offender
- ☐ Yes – Staff Member

What is the name of the healthcare facility where you reside or work?

Do you work in a food service establishment?

- ☐ No
- ☐ Yes

What is the name of the food service establishment where you work?

Do you work in food processing or manufacturing facility?

- ☐ No
- ☐ Yes

What is the name of the food processing or manufacturing facility where you work?

Do you work in another type of business?

- ☐ No
- ☐ Yes

What is the name of the business where you work?

Are you currently unemployed?

- ☐ No
- ☐ Yes

Are you retired?

- ☐ No
- ☐ Yes

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Hospitalization:

Did you spend the night in the hospital due to your COVID-19 illness or are you currently hospitalized?

- ☐ No
- ☐ Yes

What hospital where you admitted to?

When did you get admitted to the hospital?

When did you get discharged from the hospital?

If you were hospitalized a second time, what hospital were you admitted to?

2nd hospitalization – When did you get admitted to the hospital?

2nd hospitalization – When did you get discharged from the hospital?

If you were hospitalized a third time, what hospital were you admitted to?

3rd hospitalization – When did you get admitted to the hospital?

3rd hospitalization – When did you get discharged from the hospital?

Were you admitted to the intensive care unit (ICU) of the hospital?

- ☐ No
- ☐ Unsure
- ☐ Yes

Did your healthcare provider tell you that you have/had pneumonia?

- ☐ No
- ☐ Unsure
- ☐ Yes

Did your healthcare provider tell you that you have/had Acute Respiratory Distress Syndrome (ARDS)?

- ☐ No
- ☐ Unsure
- ☐ Yes

Did your healthcare provider take X-rays?

- ☐ No
- ☐ Unsure
- ☐ Yes

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Did your healthcare provider tell you that your EKG was abnormal?

- ☐ No
- ☐ Unsure
- ☐ Yes

Were you intubated (receive machine support to breathe) at the hospital?

- ☐ No
- ☐ Unsure
- ☐ Yes

If you were intubated, how many days did you receive breathing support?

Illness Information:

Were you sick around the time you were tested positive for COVID-19?

- ☐ No
- ☐ Yes

When day did you first get sick?

What day did your illness end (leave blank if still sick)?

Which of the following symptom(s) did you have? Select all that apply.

- ☐ Abdominal pain
- ☐ Chest pain
- ☐ Chills
- ☐ Cough (new onset or worsening of chronic cough)
- ☐ Diarrhea (>=3 loose stools/24hr period)
- ☐ Difficulty breathing
- ☐ Fatigue
- ☐ Fever greater than 100.4°F
- ☐ Headache
- ☐ Muscle aches
- ☐ Nausea or vomiting
- ☐ New loss of taste or smell
- ☐ Runny nose
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Subjective fever (felt feverish)
- ☐ Wheezing

Other symptom(s) (please specify):

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Pre-existing Conditions:

Do you have any of the following pre-existing conditions? Select all that apply.

- ☐ Autoimmune condition
- ☐ Chronic Kidney disease
- ☐ Chronic Liver disease
- ☐ Chronic Lung disease (asthma/emphysema/COPD)
- ☐ Current smoker
- ☐ Diabetes Mellitus
- ☐ Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment)
- ☐ Former smoker
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Immunosuppressive condition
- ☐ Pregnancy
- ☐ Severe obesity (BMI >=40)
- ☐ Substance abuse or misuse

If you have a disability, please specify.

Other chronic diseases, please specify.

Other underlying condition or risk behavior, please specify.

Travel/Exposures:

In the 14 days before you got sick (or if you were not sick, 14 days before you tested positive), did you travel to another area of Iowa (outside of the community or metropolitan area where you live)?

- ☐ Did not travel out of state
- ☐ No
- ☐ Yes

If yes, list the locations in Iowa where you traveled.

In the 14 days before you got sick (or if you were not sick, 14 days before you tested positive), did you travel to another area of state?

- ☐ Did not travel out of state
- ☐ No
- ☐ Yes

If yes, please specify.

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In the 14 days before you got sick (or if you were not sick, 14 days before you tested positive), did you travel outside of the U.S.?

- ☐ Did not travel out of state
- ☐ No
- ☐ Yes

If yes, please specify.

In the 14 days before you got sick (or if you were not sick, 14 days before you tested positive), did you have contact with another person who tested positive for COVID-19 in any of the following settings? Select all that apply.

- ☐ Adult congregate living facility (nursing, assisted living, long-term care facility or group home)
- ☐ Airplane
- ☐ Childcare
- ☐ Community event/mass gathering
- ☐ Correctional facility
- ☐ Cruise ship
- ☐ Household member
- ☐ No
- ☐ School
- ☐ Workplace

Have you had any contact with animals that tested positive for COVID-19?

- ☐ No
- ☐ Yes

If yes, please describe contact with animals.

Did you attend any group gatherings in the 14 days before you got sick (if you did not get sick, the 14 days before you were tested)?

- ☐ Bar/Restaurant
- ☐ Camp
- ☐ Concert
- ☐ Farmer's Market
- ☐ Festival
- ☐ Funeral
- ☐ N/A
- ☐ Other
- ☐ Party
- ☐ Sporting Event
- ☐ Wedding
- ☐ Worship Service

If yes, please describe the group gathering.

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If yes, what city or town was the group gathering held in?

If yes, what day was the group gathering held?

Household:

Where were you living when you got sick with COVID-19 or tested positive?

- ☐ Apartment/Townhome/Condominium
- ☐ Assisted Living Facility
- ☐ Correctional Facility
- ☐ Group Home
- ☐ Homeless Shelter
- ☐ Hospital Inpatient
- ☐ Hotel/Motel
- ☐ Long Term Care Facility
- ☐ Other
- ☐ Outside or in a car (homeless)
- ☐ Rehabilitation Facility
- ☐ Single Family Home
- ☐ University or College Housing (dormitories)

If college/university housing, please specify with name of facility, include city where facility is located.

If assisted living housing, please specify with name of facility, include city where facility is located.

If hospital housing, please specify with name of facility, include city where facility is located.

If long-term care housing, please specify with name of facility, include city where facility is located.

If housed at a correctional facility, please specify with name of facility, include city where facility is located.

Other living arrangements, please specify with name of facility, include city where facility is located.

If homeless shelter housing, please specify with name of facility, include city where facility is located.

If group home housing, please specify with name of facility, include city where facility is located.

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Case Contacts:

Contact #	Is this a household contact?	Is this person sick?	First name	Last name	Phone number	Email	Most recent close contact date	Case wore face covering	Type of face covering	Contact wore face covering	Type of face covering
1	☐	☐						☐		☐	
2	☐	☐						☐		☐	
3	☐	☐						☐		☐	
4	☐	☐						☐		☐	
5	☐	☐						☐		☐	
6	☐	☐						☐		☐	
7	☐	☐						☐		☐	
8	☐	☐						☐		☐	

Case Name _____

Contact #	Is this a household contact?	Is this person sick?	First name	Last name	Phone number	Email	Most recent close contact date	Case wore face covering	Type of face covering	Contact wore face covering	Type of face covering
9	☐	☐						☐		☐	
10	☐	☐						☐		☐	
11	☐	☐						☐		☐	
12	☐	☐						☐		☐	
13	☐	☐						☐		☐	
14	☐	☐						☐		☐	
15	☐	☐						☐		☐	
16	☐	☐						☐		☐	
17	☐	☐						☐		☐	

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Notes:

Thank you for helping public health respond to this global pandemic. It is important to remember that all people who are sick should isolate themselves from other people and animals in their home until at least 10 days since symptoms started AND At least 1 day after fever stopped AND cough and respiratory symptoms have improved. All people who are well but who test positive for COVID-19 should isolate themselves from other people and animals in their home until 10 days after the day they are tested. If your illness worsens or if you have questions about your health, contact your healthcare provider.