

Appendix 1. Andes Virus Exposure Assessment Questionnaire

Required fields are marked with an asterisk (*).

1.1 Contact Demographics

Name*	
Date of birth*	
Address*	
City*	
State*	
Residence type	<input type="checkbox"/> single family home <input type="checkbox"/> apartment/condo <input type="checkbox"/> residential care facility <input type="checkbox"/> assisted living <input type="checkbox"/> other _____
How many people, including yourself, live in the home?	
In your home, is there a room where you can isolate if you get sick?	
In your home, do you have access to a separate, private bathroom?	
Phone numbers*	Home: _____ Work: _____ Cell: _____
Emergency contact	
Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female
If female	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently employed?*	<input type="checkbox"/> Yes <input type="checkbox"/> No Job title: _____
If a healthcare worker, name of healthcare facility*	
Underlying medical conditions?*	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____
Immunocompromising medications?*	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____
The following questions are only for those who were aboard the M/V Hondius	
Room number on the M/V Hondius*	
Shared a room on M/V Hondius*	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, roommate name(s): _____
Shared a bathroom on M/V Hondius*	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, room number/name: _____
Date of boarding M/V Hondius*	
Date of disembarkation M/V Hondius*	

1.2 Exposures

Did you do any of the following activities with a person who had Andes virus (or who might have had Andes virus), specifically after they got sick? If yes, provide the date last engaged in this activity, if known.

Question / Item	Yes	No	Don't Know	Comments if Yes
Kiss or hug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Provide care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Touch or wash soiled clothes or bedding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share the same bed, bedding, or towels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep in the same room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share a bathroom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clean the room where they were staying or the bathroom they were using?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have sexual contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share unwashed utensils, food, or drink from the same plate/bowl, or beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share a toothbrush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Share a cigarette/hookah/vaping device?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Come into contact with their body fluid(s) Fluids: tears / respiratory-nasal secretions / saliva / vomit / urine / sweat / blood / stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Were within 6 feet of them in an enclosed space for at least 15 minutes cumulatively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use this space to describe any other potentially concerning exposures for discussion and assessment:				

1.3 Environmental Exposure Questions Specific to M/V Hondius Passengers

Were you in Argentina before boarding or during the voyage? Yes No

If yes, what did you do while you were there? *Describe reported activities, locations visited, dates of occurrences. If not mentioned, ask about visiting a landfill, going birding, being in rural areas.*

1.4 Symptom Inventory

Do you currently have, or have you had since your first possible exposure, any of the following symptoms?

For passengers on M/V Hondius, first exposure to an ill person on the ship is considered to be April 6. Interview should specifically include questions about symptoms on or around April 10. If individuals identify possible exposure in South America before April 6, use the date of that possible exposure as the start point.

Symptom	Yes	No	Date of onset	Current?
Fever (measured or subjective)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening headache	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening muscle aches/muscle pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening chest pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening cough	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
New or worsening difficulty breathing/shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe any signs/symptoms listed above:

1.5 Antipyretic Use

In the past 48 hours, have you taken any medications that can reduce fever, such as acetaminophen (e.g., Tylenol), ibuprofen (e.g., Motrin, Advil), naproxen (e.g., Aleve), aspirin, systemic steroids (e.g., prednisone)?

Yes No If yes, list drug(s), dose, how long (in hours) since most recent dose, and purpose:

1.6 Recent Healthcare

Since your first exposure, did you seek health care for a new illness?

Yes No N/A

If YES: Date of visit	
If YES: Healthcare personnel	
If YES: Facility name	
If YES: Facility location	City/country:
Symptoms and treatment received	

1.7 Interviewer Information

Name of person filling out this form	
Agency	
Telephone number and email	
Date and time of assessment	