

CDC *Listeria* Initiative Case Report Form

Version 2.0

Please complete this questionnaire for all laboratory-confirmed listeriosis cases.

Instructions are available in a separate two-page document.

Please remove this page before submitting form to CDC

State public health laboratory isolate ID: _____	
Patient's name: _____	Date of Birth: ____/____/____
Address: _____	
City: _____ State: ____ Zip: _____	
Phone numbers: (h) _____ (w) _____ (m) _____	
Hospital: _____ Hospital contact: _____ Phone: _____	Hospital: _____ (if >1 hospital) Hospital contact: _____ Phone: _____
<i>If surrogate interview:</i> Interviewee name: _____ Interviewee phone number(s): _____	
Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ASTSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia, 30329; ATTN: PRA (0920-0728).	

Form Approved - OMB No. 0920-0728

Log of Attempts to Call Patient or Surrogate (Optional)

(This page is for health department use only; please remove it before submitting form to CDC)

Last Name: _____

First Name: _____

	Date	Time	Caller First initial & last name	Results* (May include more than one)	Comments**	Plan
Call 1	__/__/__	__:__	__	_____	_____	_____
Call 2	__/__/__	__:__	__	_____	_____	_____
Call 3	__/__/__	__:__	__	_____	_____	_____
Call 4	__/__/__	__:__	__	_____	_____	_____
Call 5	__/__/__	__:__	__	_____	_____	_____
Call 6	__/__/__	__:__	__	_____	_____	_____
Call 7	__/__/__	__:__	__	_____	_____	_____
Call 8	__/__/__	__:__	__	_____	_____	_____
Call 9	__/__/__	__:__	__	_____	_____	_____
Call 10	__/__/__	__:__	__	_____	_____	_____
Call 11	__/__/__	__:__	__	_____	_____	_____
Call 12	__/__/__	__:__	__	_____	_____	_____
Call 13	__/__/__	__:__	__	_____	_____	_____
Call 14	__/__/__	__:__	__	_____	_____	_____
Call 15	__/__/__	__:__	__	_____	_____	_____

***Key for Results:**

- 1 Left message with person
- 2 Left message on voicemail
- 3 Did not leave message

****Key for Comments:**

- 1 Interviewed with standard questionnaire
- 2 Called back for more information
- 3 Interviewed with supplemental questionnaire
- 4 Language barrier, *indicate plan*
- 5 No answer
- 6 Phone not in service, *indicate plan*
- 7 Refused

State epi case ID _____		Local epi case ID _____		Date form completed: ____/____/____	
FoodNet ID (if applicable) _____			NNDSS ID (if available) _____		
Name of interviewer _____ first name _____ last name _____					
Was the isolate sent to public health laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If No, why not, and could it still be obtained? _____					
BOX 1: Case-patient demographic data					
State of residence _____		County _____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Age _____ (if pregnancy-associated, use age of mother)					
Ethnicity: Is the case-patient of Hispanic, Latino, or Spanish origin? (one or more categories may be selected) <input type="checkbox"/> Yes -----> If yes: <input type="checkbox"/> Mexican, Mexican American, Chicano <input type="checkbox"/> Another Hispanic, Latino, or Spanish origin (<i>specify</i>) _____ <input type="checkbox"/> No <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Unknown <input type="checkbox"/> Cuban <input type="checkbox"/> Unknown Hispanic ancestry/declined to specify <input type="checkbox"/> Declined to answer					
Race (One or more categories may be selected) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian (<i>specify</i>) <input type="checkbox"/> White (<i>specify</i>) <input type="checkbox"/> Native American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian or other Pacific Islander (<i>specify</i>) <input type="checkbox"/> Chinese <input type="checkbox"/> Not Middle Eastern/North African <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Filipino <input type="checkbox"/> Unknown <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Other (<i>specify</i>) _____ <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Declined to answer <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (<i>specify</i>) _____					
BOX 2: Is the <i>Listeria</i> case associated with pregnancy? (Illness in pregnant women, fetus, or infants ≤28 days old) <input type="checkbox"/> Yes If yes, skip to Box 4. <input type="checkbox"/> No <input type="checkbox"/> Unknown <div style="text-align: center; border: 2px solid red; padding: 5px; color: red; font-weight: bold; margin: 5px auto; width: 200px;">SEE SUPPLEMENT</div>					
BOX 3: Cases <u>not</u> associated with pregnancy (Illness in non-pregnant women, men, and children >28 days old)					
Type(s) of specimen(s) that grew <i>Listeria</i> (check all that apply)		Specimen collection date (mm/dd/yyyy)		State public health lab isolate ID # (Important: must have at least one, if available)	
<input type="checkbox"/> Blood		_____		_____	
<input type="checkbox"/> CSF		____/____/____		_____	
<input type="checkbox"/> Other (<i>specify</i>) _____		____/____/____		_____	
<input type="checkbox"/> Other (<i>specify</i>) _____		____/____/____		_____	
Did patient have any of the following type(s) of illnesses related to the <i>Listeria</i> infection? (check all that apply) <input type="checkbox"/> Bloodstream infection/sepsis <input type="checkbox"/> Meningitis <input type="checkbox"/> Meningoencephalitis <input type="checkbox"/> Brain abscess <input type="checkbox"/> Rhombencephalitis <input type="checkbox"/> Peritonitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Wound infection <input type="checkbox"/> Joint infection/septic arthritis <input type="checkbox"/> Bone infection/osteomyelitis <input type="checkbox"/> Unknown <input type="checkbox"/> Other (<i>specify</i>) _____					
Was patient hospitalized for listeriosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes: Admit date: ____/____/____ Discharge date: ____/____/____ <input type="checkbox"/> Still hospitalized as of: ____/____/____					
Patient's outcome: <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown Date of death: ____/____/____ If died: Was listeriosis or <i>Listeria</i> infection listed on death certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If survived: Last known date alive? ____/____/____					
BOX 4: Cases associated with pregnancy (Illness in pregnant woman, fetus, or infants ≤28 days old)					
Type(s) of specimen(s) that grew <i>Listeria</i> (check all that apply)		Specimen collection date (mm/dd/yyyy)		State public health lab isolate ID # (Important: must have at least one, if available)	
<input type="checkbox"/> Blood from mother		____/____/____		_____	
<input type="checkbox"/> Blood from infant		____/____/____		_____	
<input type="checkbox"/> CSF from mother		____/____/____		_____	
<input type="checkbox"/> CSF from infant		____/____/____		_____	
<input type="checkbox"/> Placenta		____/____/____		_____	
<input type="checkbox"/> Amniotic fluid		____/____/____		_____	
<input type="checkbox"/> Fetal tissue		____/____/____		_____	
<input type="checkbox"/> Other (<i>specify</i>) _____		____/____/____		_____	
<input type="checkbox"/> Other (<i>specify</i>) _____		____/____/____		_____	

Outcome of pregnancy (single gestation or twin 1) (check one)	Weeks of gestation	Date (mm/dd/yyyy)	Outcome of pregnancy (twin 2) (check one)	Weeks of gestation	Date (mm/dd/yyyy)
<input type="checkbox"/> Still pregnant		____/____/____	<input type="checkbox"/> Still pregnant		____/____/____
<input type="checkbox"/> Delivery (live birth) <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Unknown delivery type		____/____/____	<input type="checkbox"/> Delivery (live birth) <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C-section <input type="checkbox"/> Unknown delivery type		____/____/____
<input type="checkbox"/> Fetal death (miscarriage or stillbirth)		____/____/____	<input type="checkbox"/> Fetal death (miscarriage or stillbirth)		____/____/____
<input type="checkbox"/> Other (specify) _____		____/____/____	<input type="checkbox"/> Other (specify) _____		____/____/____
Type(s) of illness in mother <i>(check all that apply)</i> <input type="checkbox"/> Fever <input type="checkbox"/> Bacteremia/sepsis <input type="checkbox"/> Meningitis <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Amnionitis <input type="checkbox"/> Non-specific "flu-like" illness <input type="checkbox"/> None <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			Type(s) of illness in infant (twin 1) <i>(check all that apply)</i> <input type="checkbox"/> Bacteremia/sepsis <input type="checkbox"/> Meningitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> None <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		
Was mother hospitalized for listeriosis? <input type="checkbox"/> Yes If yes: Admit or birth date: ____/____/____ Discharge date: ____/____/____ <input type="checkbox"/> Still hospitalized Hospital name: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			Where was the infant (twin 1) delivered? <input type="checkbox"/> Hospital: Admit or birth date: ____/____/____ Discharge date: ____/____/____ <input type="checkbox"/> Still hospitalized Hospital name: _____ <input type="checkbox"/> Home <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		
			Where was infant 2 (twin 2) delivered? <input type="checkbox"/> Hospital: Admit or birth date: ____/____/____ Discharge date: ____/____/____ <input type="checkbox"/> Still hospitalized Hospital name: _____ <input type="checkbox"/> Home <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		
			Was the infant (twin 1) hospitalized for listeriosis? (may include above dates) <input type="checkbox"/> Yes If yes: Admit or birth date: ____/____/____ Discharge date: ____/____/____ <input type="checkbox"/> Still hospitalized <input type="checkbox"/> No <input type="checkbox"/> Unknown		
			Was infant 2 (twin 2) hospitalized for listeriosis? (may include above dates) <input type="checkbox"/> Yes If yes: Admit or birth date: ____/____/____ Discharge date: ____/____/____ <input type="checkbox"/> Still hospitalized <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Mother's outcome <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown If survived: Last known date alive? ____/____/____ If died: Was listeriosis/ <i>Listeria</i> infection on death certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Infant 1's (twin 1's) outcome <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown If survived: Last known date alive? ____/____/____ If died: Was listeriosis/ <i>Listeria</i> infection on death certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
			Infant 2's (twin 2's) outcome <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown If survived: Last known date alive? ____/____/____ If died: Was listeriosis/ <i>Listeria</i> infection on death certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

SUPPLEMENT

CDC *Listeria* Initiative Case Classification Supplement

Is the *Listeria* case associated with pregnancy? (Illness in a pregnant woman, fetus, or infant ≤ 28 days old)

☐ Yes (go to Box 4 Supplement) ☐ No (go to Box 3 Supplement) ☐ Unknown

Box 3 Supplement: Cases not associated with pregnancy. (Illness in non-pregnant women, men, and Children >28 days old)

State Epi Case ID: _____

Specimen Collection Information

Source (check all that apply)	Collection Date (mm/dd/yyyy)	Culture Result	CIDT Result	State public health lab isolate ID
<input type="checkbox"/> Blood	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> CSF	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (specify) _____	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (specify) _____	____/____/____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	

Laboratory Criteria for Diagnosis

Confirmatory*: Isolation of *L. monocytogenes* from a normally sterile site reflective of an invasive infection (e.g. blood, cerebrospinal fluid, pleural, peritoneal, pericardial, hepatobiliary, or vitreous fluid; orthopedic site such as bone, bone marrow, or joint; or other sterile sites including organs such as spleen, liver, and heart, but not sources such as urine, stool, or external wound)

Presumptive: Detection of *L. monocytogenes* by culture-independent diagnostic test (CIDT) in a specimen collected from a normally sterile site e.g. blood, cerebrospinal fluid, pleural, peritoneal, pericardial, hepatobiliary, or vitreous fluid; orthopedic site such as bone, bone marrow, or joint; or other sterile sites including organs such as spleen, liver, and heart, but not sources such as urine, stool, or external wound)

Supportive*: Isolation of *L. monocytogenes* from a non-invasive clinical specimen (e.g. stool, urine, wound)

*requires culture confirmation

Laboratory criteria met by case: ☐ Confirmatory ☐ Presumptive ☐ Supportive

Case Classification

(To be used to determine eligibility for interview with the *Listeria* Initiative form. Official case classifications will be determined by CDC.)

Confirmed*: A person who meets confirmatory laboratory evidence

Probable*: A person who meets the presumptive laboratory evidence

Suspect: A person with supportive laboratory evidence

* reportable to CDC

Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect

SUPPLEMENT

Box 4 Supplement: Cases associated with pregnancy. (Illness in a pregnant woman, fetus, or infant ≤ 28 days old)

Maternal State Epi Case ID: _____ Neonatal State Epi Case ID: _____

Important: If mother and neonate are counted as separate cases (see Case Classification, below), please provide the state id for both cases.

Specimen Collection Information

Maternal Source (check all that apply)	Collection Date (mm/dd/yyyy)	Culture Result	CIDT Result	State public health lab isolate ID
<input type="checkbox"/> Blood	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> CSF	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (specify) _____	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	

Products of Conception

<input type="checkbox"/> Placenta	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Amniotic fluid	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Fetal tissue (from pregnancy loss or intrauterine fetal demise)	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other product of conception (specify) _____	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> None	___/___/___	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	

Neonatal Source (check all that apply)	Collection Date (mm/dd/yyyy)	Age at Collection	Culture Result	CIDT Result	State public health lab isolate ID
<input type="checkbox"/> Blood	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> CSF	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Meconium	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Tracheal aspirate	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (specify) _____	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (specify) _____	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	
<input type="checkbox"/> None	___/___/___	<input type="checkbox"/> ≤ 48 hours <input type="checkbox"/> > 48 hours but ≤ 28 days	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	

SUPPLEMENT

Box 4 Supplement Continued

Laboratory Criteria for Diagnosis

Confirmatory*: Isolation of *L. monocytogenes* from a normally sterile site reflective of an invasive infection (e.g. blood, cerebrospinal fluid, pleural, peritoneal, pericardial, hepatobiliary, or vitreous fluid; orthopedic site such as bone, bone marrow, or joint; or other sterile sites including organs such as spleen, liver, and heart, but not sources such as urine, stool, or external wound)

OR

For MATERNAL isolates in the setting of pregnancy, pregnancy loss, intrauterine fetal demise, or birth: Isolation of *L. monocytogenes* from products of conception (e.g. chorionic villi, placenta, fetal tissue, umbilical cord blood, amniotic fluid) collected at the time of delivery

OR

For NEONATAL isolates in the setting of live birth: Isolation of *L. monocytogenes* from a non-sterile neonatal specimen (e.g. meconium, tracheal aspirate, but not products of conception) collected within 48 hours of delivery

Presumptive: Detection of *L. monocytogenes* by culture-independent diagnostic test (CIDT) in a specimen collected from a normally sterile site e.g. blood, cerebrospinal fluid, pleural, peritoneal, pericardial, hepatobiliary, or vitreous fluid; orthopedic site such as bone, bone marrow, or joint; or other sterile sites including organs such as spleen, liver, and heart, but not sources such as urine, stool, or external wound)

OR

For MATERNAL isolates in the setting of pregnancy, pregnancy loss, intrauterine fetal demise, or birth: Detection of *L. monocytogenes* from products of conception (e.g. chorionic villi, placenta, fetal tissue, umbilical cord blood, amniotic fluid) collected at the time of delivery

OR

For NEONATAL isolates in the setting of live birth: Detection of *L. monocytogenes* from a non-sterile neonatal specimen (e.g. meconium, tracheal aspirate, but not products of conception) collected within 48 hours of delivery

Supportive*: Isolation of *L. monocytogenes* from a non-invasive clinical specimen (e.g. stool, urine, wound, other than those specified under maternal and neonatal specimens above)

*requires culture confirmation

Laboratory criteria met by maternal case: ☐ Confirmatory ☐ Presumptive ☐ Supportive ☐ None

Laboratory criteria met by neonatal case: ☐ Confirmatory ☐ Presumptive ☐ Supportive ☐ None

Case Classification

(To be used to determine eligibility for interview with the Listeria Initiative form. Official case classifications will be determined by CDC.) **Confirmed*:** A person who meets confirmatory laboratory evidence

Probable*: A person who meets the presumptive laboratory evidence

OR

A mother or neonate who meets epidemiologic linkage criteria but who does not have confirmatory laboratory evidence (See Epidemiologic Linkage, below)

Suspect: A person with supportive laboratory evidence

* reportable to CDC

Notes:

Pregnancy loss and intrauterine fetal demise are considered maternal outcomes and would be counted as a single case in the mother.

A case in a neonate is counted if live-born.

If multiple criteria are met, the highest level of classification should be reported for each case.

SUPPLEMENT

Epidemiologic Linkage

For PROBABLE MATERNAL cases: A mother who does not meet the confirmed case criteria,
BUT who gave birth to a neonate who meets the confirmatory or presumptive laboratory evidence for diagnosis,
AND the neonatal specimen was collected ≤ 28 days after birth

For PROBABLE NEONATAL cases: A neonate who does not meet the confirmed case criteria
AND whose mother meets confirmatory or presumptive laboratory evidence for diagnosis from products of conception
OR a clinically compatible neonate whose mother meets confirmatory or presumptive laboratory evidence for diagnosis from a normally sterile site

Maternal Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
If Probable, does case have an epidemiologic link to a neonatal case? ☐ Yes ☐ No ☐ Unknown

Neonatal Case Classification: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Not applicable (pregnancy loss or intrauterine fetal demise)

If Probable, does case have an epidemiologic link to a maternal case? ☐ Yes ☐ No ☐ Unknown

If Confirmed or Probable:

Age of infant: _____ ☐ day(s) ☐ month(s) Sex of infant: ☐ Male ☐ Female

BOX 5: (Optional): Underlying conditions and treatments (Check all that apply and specify when information available)

<input type="checkbox"/> No underlying conditions, medications, or treatments (previously healthy) <input type="checkbox"/> Cancer/malignancy <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Hodgkin's <input type="checkbox"/> Non-Hodgkin's <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Myeloproliferative disorder <input type="checkbox"/> Other cancer/malignancy (<i>specify</i>) _____ <input type="checkbox"/> On kidney dialysis <input type="checkbox"/> Cirrhosis/advanced liver disease <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Heart disease (<i>specify</i>) _____ <input type="checkbox"/> Organ transplant (<i>specify</i>) _____	<input type="checkbox"/> Unknown <input type="checkbox"/> Other conditions <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Giant cell (temporal) arteritis <input type="checkbox"/> Hemochromatosis/iron overload <input type="checkbox"/> HIV/AIDS* <input type="checkbox"/> HIV (no AIDS) <input type="checkbox"/> AIDS <input type="checkbox"/> Lupus <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Splenectomy/asplenia <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other condition (<i>specify</i>) _____	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Immunosuppressive medication <input type="checkbox"/> Corticosteroids/steroids <input type="checkbox"/> Cancer chemotherapy <input type="checkbox"/> Other immunosuppressive therapy (<i>specify</i>) _____ <input type="checkbox"/> Excessive alcohol use <input type="checkbox"/> Injection drug use, e.g., heroin <input type="checkbox"/> Medications that suppress stomach acid (e.g., Maalox, Zantac, Prilosec, Nexium) <i>(specify medications, if available):</i> _____ <i>*Note that some regulations in some states do not permit reporting of HIV status</i>
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Was patient or surrogate able to be interviewed? ☐ Yes ☐ No

If no, why not? ☐ Refused ☐ Unable to reach ☐ Language barrier ☐ Other (*specify*) _____

If you are not able to interview the patient or surrogate and no food exposure information is available, please submit only pages 3–5 of this form to CDC.
(Please also include page 6 if you are able to record symptoms associated with listeriosis)

Please send completed forms to:
 Enteric Diseases Epidemiology Branch, Centers for Disease Control and Prevention
 Mailstop C-09
 Atlanta, GA 30329.
 Fax: (404) 639-2205; Email: Listeria@cdc.gov.

1. Patient Interview		Interviewer: In the question stems and interviewee instructions, the text "<case>" is used in place of "you/he/she," and "<case's>" is used in place of "your/his/her." For pregnancy-associated cases, the mother is the case-patient and she should be asked about her food history during the 4 weeks before delivery.	
1. Date of interview ____/____/____	2. Respondent was <input type="checkbox"/> Case-patient <input type="checkbox"/> Surrogate <input type="checkbox"/> Unknown <input type="checkbox"/> None available (chart review only) If surrogate, relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other, Specify _____		
3. When did <case's> illness begin? (Onset of illness) ____/____/____ <input type="checkbox"/> Not applicable (e.g. pregnant woman without clinical illness)			
4. During the 4 weeks before <case's> illness/delivery date, was <case> admitted to a hospital (i.e., stayed at least overnight)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, Hospital name _____ Admission date: ____/____/____ Discharge date: ____/____/____ or <input type="checkbox"/> Still hospitalized		5. During the 4 weeks before <case's> illness/delivery date, was <case> a resident in a nursing home or other long term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, Facility name _____ Admission date: ____/____/____ Discharge date: ____/____/____ or <input type="checkbox"/> Still residing in facility	
6. During the 4 weeks before <case's> illness/delivery date, did <case> travel to a state outside of <case's> state of residence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, please list states visited _____		7. During the 4 weeks before <case's> illness/delivery date, did <case> travel outside the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, Names of countries visited _____ If yes, Date of departure from U.S. ____/____/____ Date of return to U.S. ____/____/____	
8. Which of the following symptoms were associated with illness? (read each) (ask mother for her symptoms if case was pregnancy-associated or in infant ≤ 28 days old)			
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Diarrhea (≥3 loose stools/day) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Preterm labor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> N/A Muscle Aches <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		Stiff Neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Altered mental status <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other (specify) _____ Other (specify) _____
2. Food History Interviewer: In this section, "case" refers to patient except when patient is infant ≤ 28 days old, when questions apply to mother.			
"I am interested in the foods <case> ate during the 4 weeks before <case's> illness/delivery, which I see was on ____/____/____. For most of the interview, I will be asking you questions about the 4 weeks before this date, starting ____/____/____ (date 4 weeks before) through ____/____/____. It might be helpful to look at a calendar available for reference, if possible."			
1. Did <case> have any allergies that prevented <case> from eating certain foods? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 1a. If yes: What foods? <input type="checkbox"/> Milk <input type="checkbox"/> Eggs <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nuts <input type="checkbox"/> Fish <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Shellfish <input type="checkbox"/> Other (specify) _____		2. Did <case> have a vegetarian or vegan diet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 2a. If yes, Which one? <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan	
3. Did <case> have a special or restricted diet (medical, weight-loss, religious, cultural) or are there any types of foods <case> didn't eat? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 3a. If yes: Please Describe: _____			
Food Purchase History (the lists of store and restaurant types below are meant to prompt the respondent)			
A. Sources of food at home: "Now I have a few questions about where the food came from that <case> ate at home in the 4 weeks before <case's> illness began. I'm going to list several types of stores. For each type, please tell me the names of each store <case> would have eaten food from during the 4 weeks before <case> was sick. Did <case> eat foods from?"			
• Grocery stores or supermarkets • Warehouse stores, such as Costco or Sam's Club • Small markets (convenience stores, gas stations, etc.)		• Ethnic specialty markets (e.g., Mexican, Asian) • Farmer's markets • Online stores or foods received by mail	
• Did <case> eat food at home from any other place during the 4 weeks before illness began?			
Store Name	Location (address, city, state)		
1.			
2.			
3.			
4.			
5.			
Would you be willing to release your shopper card information so we can get an exact list of your foods and when they were purchased? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None available		Store name: _____ Shopper card #: _____ Store name: _____ Shopper card #: _____ Store name: _____ Shopper card #: _____	
B. Restaurants: "Now I have a few questions about restaurants where <case> might have eaten. For each type of restaurant, please tell me the names of every restaurant <case> ate food from during the 4 weeks before <case> was sick. Did <case> eat foods from...?" (interviewer name all types)			
• Buffet-style (where you serve yourself) • Ethnic restaurants that are not fast-food, such as Mexican, Italian, Chinese		• Sandwich shops or delis • Fast-food (drive up or pay at counter) • Any other type of restaurant	
Restaurant Name	Location (address, city, state)	What foods did <case> eat?	Date(s)
1.			
2.			
3.			
4.			
5.			

C. Other locations: "Did <case> eat food purchased or obtained from any other locations, such as salad bars (including at grocery stores), cafeterias, food trucks, picnics, potlucks, concession stands, institutions (e.g. hospital food), local farms or dairies, or special events like weddings or parties during the 4 week period?"

Location Name	Location (address, city, state)	What foods did <case> eat?	Date(s)
1.			
2.			
3.			

3 . Food Consumption History

"Now I'd like to ask you about the foods that <case> ate during that same 4 week period. For each food item, please give me your best guess as to whether <case> ate the food. If you're not sure, you can tell me whether <case> likely ate or likely did NOT eat the food. If you have no idea, please say 'don't know.' I'll start by asking about cheeses."

A. Cheese	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Made from raw milk? (circle one)	Place of purchase or consumption
Feta	1	2	3	4	99		Y N DK	
Goat cheese	1	2	3	4	99		Y N DK	
Blue-veined cheese (gorgonzola, bleu)	1	2	3	4	99		Y N DK	
Brie or camembert	1	2	3	4	99		Y N DK	
Gouda	1	2	3	4	99		Y N DK	
Prepackaged, shredded cheese	1	2	3	4	99		Y N DK	
Fresh mozzarella, sold in water	1	2	3	4	99		Y N DK	
Cottage cheese	1	2	3	4	99		Y N DK	
Ricotta cheese	1	2	3	4	99		Y N DK	
Other gourmet, fancy, or artisanal cheese	1	2	3	4	99		Y N DK	
Any cheese sliced at a deli counter	1	2	3	4	99		Y N DK	
Middle Eastern-style cheese (e.g., akawi, nabulsi)	1	2	3	4	99		Y N DK	
Mexican- or Latin-style cheese (e.g., queso fresco)	1	2	3	4	99		Y N DK	

If ate or likely ate Mexican- or Latin-style cheese, **what type(s)?**

- Queso fresco	1	2	3	4	99		Y N DK	
- Queso blanco	1	2	3	4	99		Y N DK	
- Queso casero	1	2	3	4	99		Y N DK	
- Cuajada	1	2	3	4	99		Y N DK	
- Asadero	1	2	3	4	99		Y N DK	
- Cotija	1	2	3	4	99		Y N DK	
- Panella	1	2	3	4	99		Y N DK	
- Queso ranchero	1	2	3	4	99		Y N DK	
- Requeson	1	2	3	4	99		Y N DK	
- Oaxaca	1	2	3	4	99		Y N DK	
- Other Mexican- or Latin- style cheese (specify) _____	1	2	3	4	99		Y N DK	
Other soft cheese (not cream, cottage, or ricotta) — specify type _____	1	2	3	4	99		Y N DK	
Any cheese from raw/ unpasteurized milk	1	2	3	4	99		Y N DK	
Any other cheeses (specify) _____	1	2	3	4	99		Y N DK	

B. Other Dairy	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
"Now I'd like to ask you about other dairy items that <case> ate in the 4 weeks before <case's> illness began."							
Milk	1	2	3	4	99		
	If 1 or 2, Was any of this milk raw (unpasteurized)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
- Whole	1	2	3	4	99		
- 2%	1	2	3	4	99		
- 1%	1	2	3	4	99		
- Skim	1	2	3	4	99		
- Other milk (e.g., chocolate, buttermilk)	1	2	3	4	99		
Non-dairy milk (e.g., soy, almond—specify) _____	1	2	3	4	99		
Frozen yogurt	1	2	3	4	99		
Yogurt	1	2	3	4	99		
	If 1 or 2, Was any of this yogurt raw (unpasteurized)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify type, if yes _____						
Yogurt drinks	1	2	3	4	99		
Butter (not margarine or other butter substitute)	1	2	3	4	99		
Cream or half-and-half	1	2	3	4	99		
Ice cream bars, milkshakes, or frozen dairy dessert items	1	2	3	4	99		
Ice cream	1	2	3	4	99		
	Was any of the ice cream soft serve? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Sour cream or crema	1	2	3	4	99		
C. Seafood	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
"Now I have some questions about seafood <case> might have eaten in the 4 weeks before <case's> illness began."							
Precooked shrimp	1	2	3	4	99		
Precooked shellfish (e.g., crab, mussels, clams— specify) _____	1	2	3	4	99		
Refrigerated smoked or cured fish that was not from a can (e.g., smoked salmon)	1	2	3	4	99		
Any raw fish or seafood, including sushi	1	2	3	4	99		
Frozen processed seafood (e.g., fish sticks or breaded fish)	1	2	3	4	99		
D. Dips and Spreads	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
"Now I have some questions about dips and spreads <case> might have eaten in the 4 weeks before <case's> illness began."							
Hummus	1	2	3	4	99		
Refrigerated, fresh salsa or pico de gallo (not from a jar or can)	1	2	3	4	99		
Guacamole	1	2	3	4	99		
Other dips or spreads (specify) _____	1	2	3	4	99		

E. Fruit	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
"Now I have some questions about <u>fresh, frozen, or dried</u> fruits, but not canned or cooked, <case> might have eaten in the 4 weeks before <case's> illness began. Again, I'm interested in fresh, frozen, or dried."							
Apples, including apple slices	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
	If 1 or 2, were items purchased pre-sliced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Caramel apples	1	2	3	4	99		
Grapes	1	2	3	4	99		
Raisins	1	2	3	4	99		
Pears	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Peaches	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Nectarines	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Apricots	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Plums	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Strawberries	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Raspberries	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Blueberries	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Blackberries	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Cherries	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Honeydew melon	1	2	3	4	99		
	If 1 or 2, were items purchased pre-sliced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Cantaloupe	1	2	3	4	99		
	If 1 or 2, were items purchased pre-sliced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Watermelon	1	2	3	4	99		
	If 1 or 2, were items purchased pre-sliced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Pineapple	1	2	3	4	99		
	If 1 or 2, were items purchased pre-sliced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Mango	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
	If 1 or 2, were items purchased pre-sliced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK						
Papaya	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Avocado (including homemade guacamole)	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Fruit salad (including pre-cut cubes of a single fruit)	1	2	3	4	99		
Other fruit (<i>specify</i>) _____	1	2	3	4	99	<input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Dried	
Fruit sorbet	1	2	3	4	99		
F. Animal Contact	Contact (=1)	Likely contact (=2)	Likely NO contact (=3)	NO contact (=4)	Don't know (=99)	Type of animal or pet food	Place of contact or purchase
"Now I have three questions about animal contact <case> might have had in the 4 weeks before <case's> illness began."							
Spent time at a petting zoo, farm, or other venue with livestock, such as cattle, sheep, goats, etc.	1	2	3	4	99		
Fed a cat or dog <u>raw</u> pet food (i.e., pet food marketed as raw)	1	2	3	4	99		
Fed a cat or dog refrigerated, frozen, or freeze-dried pet treats	1	2	3	4	99		

G. Deli Meats	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
<i>"For this section, I'm going to ask you questions about deli meats <case> might have eaten in the 4 weeks before <case's> illness began."</i>							
Ham	1	2	3	4	99		
If 1 or 2, Was this item sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Bologna	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Turkey breast	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Chicken deli meat (NOT fresh or rotisserie chicken)	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Roast beef	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Pastrami or corned beef	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Liverwurst or braunschweiger	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Paté or meat spread that was not canned	1	2	3	4	99		
Head cheese	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Pepperoni	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Any other Italian-style meats, such as salami or prosciutto	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Other deli/luncheon meat (specify) _____	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Anything from a deli area where meat is sliced	1	2	3	4	99		
If 1 or 2, Sliced at a deli counter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
H. Other Meat/ Poultry	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
<i>"Now I have some questions about other meat and poultry, including ready-to-eat items, <case> might have eaten in the 4 weeks before <case's> illness began."</i>							
Precooked sausage	1	2	3	4	99		
Precooked chicken (whole or parts, including rotisserie)	1	2	3	4	99		
Other precooked meat (specify) _____	1	2	3	4	99		
Cured or dried meat (e.g., jerky)	1	2	3	4	99		
Hot dogs	1	2	3	4	99		
If 1 or 2, Were the hot dogs: <input type="checkbox"/> Heated before being eaten <input type="checkbox"/> Not heated before being eaten (eaten directly out of package) <input type="checkbox"/> DK							
Frozen processed poultry (e.g., chicken nuggets or turkey pot pie—specify) _____	1	2	3	4	99		
Ground chicken or turkey (specify) _____	1	2	3	4	99		

I. Vegetables and other produce	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
"Now I have some questions about vegetables, not canned or cooked, <case> might have eaten in the 4 weeks before <case's> illness began."							
Sprouts (including in a sandwich, salad, soup, sushi, or other food)	1	2	3	4	99		
If 1 or 2, Which of the following types of sprouts did you eat?							
- Alfalfa	1	2	3	4	99		
- Bean (e.g. mung, soybean)	1	2	3	4	99		
- Clover	1	2	3	4	99		
- Radish	1	2	3	4	99		
- Broccoli	1	2	3	4	99		
- Mixed	1	2	3	4	99		
- Other sprouts (specify) _____	1	2	3	4	99		
Cucumbers	1	2	3	4	99		
Pea pods/snap peas/snow peas	1	2	3	4	99		
Sweet peppers (green, red, orange, or yellow bell peppers)	1	2	3	4	99		
Hot chili peppers such as jalapenos or serranos	1	2	3	4	99		
Green onions or scallions	1	2	3	4	99		
Celery	1	2	3	4	99		
Mini-carrots	1	2	3	4	99		
Fresh mushrooms	1	2	3	4	99		
Pre-cut raw vegetables or vegetable mixes (e.g., celery, onions—specify) _____	1	2	3	4	99		
Fresh basil	1	2	3	4	99		
Fresh cilantro	1	2	3	4	99		
Fresh parsley	1	2	3	4	99		
Other fresh herbs (sage, thyme, dill, etc.—specify) _____	1	2	3	4	99		
Fresh tomatoes	1	2	3	4	99		
If 1 or 2, what type(s) of tomatoes?							
- Red round	1	2	3	4	99		
- Roma	1	2	3	4	99		
- Cherry/grape	1	2	3	4	99		
- Vine-ripe, sold on vine	1	2	3	4	99		
- Other (specify) _____	1	2	3	4	99		
Any lettuce	1	2	3	4	99		
If 1 or 2, Was any of this lettuce prepackaged? <input type="checkbox"/> Yes (specify type & brand) <input type="checkbox"/> No <input type="checkbox"/> DK _____							
If 1 or 2, what type(s) of lettuce?							
- Iceberg	1	2	3	4	99		
- Romaine	1	2	3	4	99		
- Mesclun ("spring mix")	1	2	3	4	99		
- Radish	1	2	3	4	99		
- Any other leaf lettuce (specify) _____	1	2	3	4	99		

I. Vegetables and other produce (Continued)	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
Other prepackaged leafy green (e.g., kale, spinach— <i>specify</i>)	1	2	3	4	99		
Premade green salad that includes other ingredients besides greens (e.g., cobb, Caesar salads)	1	2	3	4	99		
Other produce (<i>specify</i>)	1	2	3	4	99		
J. Deli Salads	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
<i>"Now I have some questions about deli salads that <case> might have eaten in the 4 weeks before <case's> illness began. Please do not include homemade items, but only those made in a factory, restaurant, or outside the home."</i>							
Potato salad	1	2	3	4	99		
<i>If 1 or 2, Was this item purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Pasta salad	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Egg salad	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Tuna salad	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Chicken salad	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Bean salad	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Seafood salad	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Cole slaw	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Other ready-to-eat meat or vegetable salad not made at home	1	2	3	4	99		
<i>If 1 or 2, Purchased from a deli counter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK							
Anything from a salad bar	1	2	3	4	99		

K. Other Foods	Ate (=1)	Likely ate (=2)	Likely did NOT eat (=3)	Did NOT eat (=4)	Don't know (=99)	Details (e.g., type, variety, brand, packaging, shape/size, how prepared)	Place of purchase or consumption
<i>"Now I have some questions about other foods <case> might have eaten in the 4 weeks before <case's> illness began."</i>							
Freshly-made smoothie with fresh or frozen fruit or produce	1	2	3	4	99		
Tahini	1	2	3	4	99		
Tofu, tempeh, or seitan	1	2	3	4	99		
Rice noodles	1	2	3	4	99		
Sandwiches from a refrigerated case or vending machine	1	2	3	4	99		
Peanut butter or other nut butters or nut cheeses	1	2	3	4	99		
Nuts, including peanuts, almonds, cashews	1	2	3	4	99		
Seeds, including chia, hemp, flax, or sunflower	1	2	3	4	99		
Food brought here from another country	1	2	3	4	99		
Any seasonal foods or special foods <case> ate during the last 4 weeks? _____							
Are there any other food items <case> ate that we didn't talk about already? _____							

Optional questions: (Interviewer note: These questions can be helpful in outbreak investigations and for targeting prevention efforts.)							
1. In what country was <case> born? <input type="checkbox"/> In the United States or its territories (e.g., Puerto Rico, Guam) <input type="checkbox"/> Outside the United States (specify) _____ <i>If outside the United States: What year did this person come to live in the United States?</i> _____							
2. What is <case's> primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown							