

SHIGELLA HYPOTHESIS GENERATING QUESTIONNAIRE

PULSENET CLUSTER CODE: <CLUSTER CODE>

](ENTER CLUSTER CODE)

[Please complete Section 1 prior to conducting interview]

Section 1: INTERVIEW INFORMATION

1. PulseNet ID #: _____	2. WGS ID #: _____
3. Interviewer information Name: _____ Agency or organization: _____	
4. Reporting state: _____	5. Reporting county: _____
6. Language interview conducted in: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify): _____	
7. Respondent was: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify): _____	

Hello, my name is <interviewer name>. I am from <interviewer health department name>. We are contacting you because you (your child) were recently sick with a *Shigella* infection, also called shigellosis. *Shigella* are a group of bacteria that cause diarrheal illness. We are trying to determine how you (your child) became sick with a *Shigella* infection. This interview will also help prevent others from getting sick.

You may have already been contacted by the health department. I would like to ask you a few additional questions about your (your child's) recent illness and about any exposures you (your child) may have had before becoming ill. Your help in the investigation is very important. Your participation is voluntary, and you may refuse to answer any question at any time. All information will be kept confidential to the extent permitted by law. No names or other identifying information will be used in any reports. This interview will likely take about 25 to 30 minutes. Are you willing to participate?

If yes: Thank you. [Proceed to Section 2]

If no: Thank you for your time. Would you like any additional materials about *Shigella* or can I answer any questions for you? If you wish at any time to complete the questionnaire, please call <health department phone number>.

For the first few questions, I will ask some basic demographic questions so I can learn more about you (your child).

Section 2: CASE INFORMATION

1. State (of residence): _____	2. County (of residence): _____
3. Age (of case): _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	
4. What sex were you (your child) assigned at birth? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
How do you describe your (your child's):	
6. Ethnicity? <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	

7. Race? (select all that apply) American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Pacific Islander White Refused

8. If case is ≥14 years old, what is your (your child's) current occupation? _____

Now I am interested to learn a little about your household.

Section 3: HOUSEHOLD INFORMATION

1. What would best describe the type of housing you (your child) currently live in? For example, a house, apartment, or mobile home.
 House/single family home Apartment Hotel/motel Long term care facility Nursing home/assisted living facility
 Mobile home Shelter Rehabilitation center Half-way house Unknown Other (specify): _____

2. In the past 30 days, did you (your child) double up or stay overnight with friends, relatives, or someone you didn't know well because you didn't have a regular place to stay at night? Yes No Prefer not to answer Unknown

3. In the past 30 days, were you ever homeless? That is, were you living on the street, in a shelter, in a single room occupancy hotel, or in a car? Yes No Prefer not to answer Unknown

4. What is the water source at your (your child's) primary place of residence?
 Municipal Well Unknown Other (specify): _____

5. What is the sewer connection at your (your child's) primary place of residence?
 Municipal Septic tank Unknown Other (specify): _____

6. How many people, including you (your child), live in your (your child's) primary place of residence? _____ Unknown
a. Do any of these people (either children or adults) wear diapers? Yes No Unknown
b. How many people living in your household are under the age of 5? _____ Unknown

7. What was your household income last year from all sources before taxes? That is, the total amount of money earned and shared by all people living in your household.
 <\$20,000 \$20,000-\$39,999 \$40,000-\$59,999 \$60,000-\$79,999 \$80,000-99,999 >\$100,000
 Prefer not to answer Unknown

Next, I have a few questions about your (your child's) recent illness. It may be helpful to have a calendar in front of you because I will be asking about the dates your (your child's) symptoms started and stopped. Do you need some time to get one?

Section 4: CLINICAL INFORMATION

1. What date did you (your child) first feel sick? _____ / _____ / _____ Approximate date Unknown
Month / Day / Year

2. What date did you (your child) stop feeling sick? _____ / _____ / _____ Approximate date Unknown Ongoing
Month / Day / Year
a. If unsure of specific dates in questions 1 and 2, about how many days were you (was your child) sick? _____

Yes	No	Don't Know	3. Have you (your child) had any of the following symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Diarrhea (at least 3 loose, watery stools in 24 hours)
			i. If yes to question 3a, about how many days did you (your child) have diarrhea? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Abdominal pain/cramps
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Nausea

Public reporting burden of this collection of information is estimated to average 45 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/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Bloody stools/bloody diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Achy joints/muscles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Tenesmus (or feeling the need to pass stool [poop] even when bowels are empty)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Other symptoms I didn't ask about (specify): _____

The next set of questions are about any recent medical care and treatment you (your child) may have received.

Section 5: MEDICAL CARE AND TREATMENT INFORMATION			
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. As a result of your (your child's) illness, did you (your child) seek medical care?
			a. If yes to question 1, where did you (your child) seek medical care? (select all that apply) <input type="checkbox"/> Doctor's office <input type="checkbox"/> Urgent care <input type="checkbox"/> Pharmacy clinic <input type="checkbox"/> STD clinic <input type="checkbox"/> Emergency department <input type="checkbox"/> Hospital <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. If yes to question 1, were you (your child) admitted to a hospital overnight?
			i. If yes to question 1b, for how many nights were you (your child) hospitalized? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. If yes to question 1, were you (your child) admitted to the intensive care unit?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In addition to infection with <i>Shigella</i> , did your (your child's) doctor tell you that you were sick with any other infection(s)?
			a. If yes to question 2, what was the name of the other infection(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Were you (was your child) prescribed any antibiotics for this illness? If yes, I will be asking more questions about the antibiotic, so it may be helpful to get the pill bottles or packages if available.
			a. If yes to question 3, what was the name of the antibiotic(s), dose, and frequency? _____
			b. If yes to question 3, which date did you (your child) start taking the antibiotic(s)? ____/____/____ <input type="checkbox"/> Approximate date <input type="checkbox"/> Unknown Month / Day / Year
			c. If yes to question 3, which date did you (your child) stop taking the antibiotic(s)? ____/____/____ <input type="checkbox"/> Approximate date <input type="checkbox"/> Unknown <input type="checkbox"/> Still taking antibiotic(s) Month / Day / Year
			d. If yes to question 3, in the 24 hours after taking the antibiotic(s), did your (your child's) symptoms <input type="checkbox"/> Get better/Improve <input type="checkbox"/> Stay the Same <input type="checkbox"/> Get Worse <input type="checkbox"/> Other (specify): _____

I would now like to know about your (your child's) recent activities, including travel, events, and contact with others.

Section 6: EXPOSURE INFORMATION			
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the <u>7 days before</u> your illness started, did you (your child) spend any time outside of your home state?

			<p>a. If yes to question 1, list all U.S. states where you (your child) traveled:</p> <p>_____</p> <p>i. List dates of domestic travel: _____</p> <p>ii. What was the purpose of this travel? (select all that apply) <input type="checkbox"/> Tourism <input type="checkbox"/> Work <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Other (specify): _____</p> <p>iii. Where did you (your child) stay while traveling domestically? (select all that apply): <input type="checkbox"/> Hotel, hostel, guest house, resort <input type="checkbox"/> Private home <input type="checkbox"/> Hospital <input type="checkbox"/> Cruise ship <input type="checkbox"/> Other (e.g., school, dormitory, tent) (specify): _____</p> <p>iv. What activities did you (your child) engage in while traveling domestically? (select all that apply) <input type="checkbox"/> Purchase or eat food <input type="checkbox"/> Go swimming <input type="checkbox"/> Attend gathering of people <input type="checkbox"/> Drink untreated water <input type="checkbox"/> Other (specify): _____</p>
			<p>b. If yes to question 1, list all countries outside the United States where you (your child) traveled:</p> <p>_____</p> <p>i. List dates of international travel: _____</p> <p>ii. What was the purpose of this travel? (select all that apply) <input type="checkbox"/> Tourism <input type="checkbox"/> Work <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Other (specify): _____</p> <p>iii. Where did you (your child) stay while traveling internationally? (select all that apply): <input type="checkbox"/> Hotel, hostel, guest house, resort <input type="checkbox"/> Private home <input type="checkbox"/> Hospital <input type="checkbox"/> Cruise ship <input type="checkbox"/> Other (e.g., school, dormitory, tent) (specify): _____</p> <p>iv. What activities did you (your child) engage in while traveling internationally? (select all that apply) <input type="checkbox"/> Purchase or eat food <input type="checkbox"/> Go swimming <input type="checkbox"/> Attend gathering of people <input type="checkbox"/> Drink untreated water <input type="checkbox"/> Other (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>2. In the <u>past month</u>, have you (your child) had contact with any individuals who traveled outside the United States?</p>
			<p>a. If yes to question 2, where did they travel? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>b. If yes to question 2, were they ill with symptoms similar to your (your child's) symptoms?</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>c. If yes to question 2, did you (your child) eat any food or drink any beverages they brought back?</p>
			<p>i. If yes to question 2c, what did you (your child) eat or drink? (specify): _____</p>
			<p>3. In the <u>7 days before</u> your (your child's) illness started, did you (your child) attend, visit, work in, or volunteer at any of the following:</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>a. A religious gathering (such as church, mosque, or synagogue)? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>b. Camp? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>c. Conference or other large meeting? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>d. Festival, fair, play, or concert? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>e. Party, picnic, or barbeque? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>f. Sports practice, sports game, or exercise class? (specify): _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>g. Other gathering of people I did not ask about? (specify): _____</p>
Yes	No	Don't	<p>4. In the <u>7 days before</u> your (your child's) illness started, did you (your child):</p>

		Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Drink water from an untreated source, such as lake, pond, or river? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Eat any foods prepared by a friend, neighbor, or coworker in their home? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Eat any foods prepared by a catering company? (such as food served at a wedding or conference?) (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Eat at a restaurant? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Swim in treated water, such as a swimming pool? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Swim in untreated water, such as a lake, river, or ocean? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Play in an interactive water fountain, water table, children's pool, kiddie pool, or baby pool? (specify): _____
			5. In the <u>7 days before</u> your (your child's) illness started, did you (your child) visit, work in, or volunteer at:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. A place that serves food, such as a restaurant or cafeteria? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. A homeless shelter? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. A health care facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. A nursing home, long term care, or assisted living facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. In the <u>7 days before</u> your (your child's) illness started, did you (your child) have contact with someone with diarrhea (at least 3 loose, watery stools in 24 hours) or symptoms similar to your (your child's) symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. If yes to question 6, was this person diagnosed with a <i>Shigella</i> infection?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. If yes to question 6, was this person a member of your (your child's) household? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. If yes to question 6, does this person wear diapers?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. If yes to question 6e, did you (your child) change this person's diapers?
			7. <u>While you (your child) were sick with the <i>Shigella</i> infection, did you (your child) do any of the following:</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Prepare or handle food for other people? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Go swimming or play in a swimming pool, baby pool, interactive fountain, or water table? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Visit, work in, or volunteer at a healthcare facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Visit, work in, or volunteer at a nursing home, long term care, or assisted living facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Visit, work in, volunteer, or attend a school or childcare facility? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Visit, work in, volunteer, or attend any gathering of people? For example, a picnic, party, concert, conference, or religious gathering. (specify): _____

We are nearly finished. I have a few questions about your (your child's) recent child care or school attendance.

Section 7: CHILD CARE AND SCHOOL INFORMATION

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. In the <u>7 days before</u> your (your child's) illness started, did you (your child) visit, work in, volunteer, or attend a child care center, daycare, or preschool?
			a. If yes to question 1, what is the name of the facility? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. If yes to question 1, at this facility were there any other children or adults ill with diarrhea (at least 3 loose, watery stools in 24 hours) or symptoms similar to yours (your child's) before you (your child) became ill?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. If yes to question 1, did you (your child) use a school bus or other school transport to get to and from the child care center, daycare, or preschool?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. If yes to question 1, were you (your child) excluded from this facility while ill?
			i. If yes to question 1d, how many days were you (your child) excluded? _____
			ii. If yes to question 1d and case is ≤ 18 years, while excluded from daycare, what alternative care did your child receive? (select all that apply) <input type="checkbox"/> Babysitter <input type="checkbox"/> Care at home <input type="checkbox"/> Other child care center <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. In the <u>7 days before</u> your (your child's) illness started, did you (your child) attend, visit, work in, or volunteer in a school (such as an elementary, middle, after school center, or other type of school)?
			a. If yes to question 2, what is the name of the school? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. If yes to question 2, at this school were there any other children or adults ill with diarrhea (at least 3 loose, watery stools in 24 hours) or symptoms similar to your (your child's) before you became ill?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. If yes to question 2, did you (your child) use a school bus or other school transport to get to and from the school?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. If yes to question 2, were you (your child) excluded from school while ill?
			i. If yes to question 2d, how many days were you (your child) excluded? _____
			ii. If yes to question 2d and case is ≤ 18 years, while excluded from school, what alternative care did your child receive? (select all that apply) <input type="checkbox"/> Babysitter <input type="checkbox"/> Care at home <input type="checkbox"/> Self-care <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____

[Proceed if participant is ≥ 18 years of age. Otherwise skip section 8 and conclude interview]

Finally, I would like to ask about your recent sexual activity because *Shigella* can be spread through sexual contact. *Shigella* germs are very contagious; it takes just a small number of *Shigella* germs to make someone sick. People can get shigellosis when they put something in their mouths or swallow something that has come into contact with the stool of someone else who is sick with shigellosis. This can happen during sex.

As I stated previously, your responses are voluntary, and you may refuse to answer any question at any time. We ask all adults who were diagnosed with a *Shigella* infection these questions. Your answers to these questions will be kept private and may help us to identify how you became sick with a *Shigella* infection. This will also help us to prevent others from getting sick.

Do you wish to proceed with the next section?

If yes: Thank you [*Begin section 8*]

If no: That is OK. We appreciate the information you have given us. Refused/Prefer Not to Complete
 [*Skip to Section 9 to close out interview*]

Section 8: RECENT SEXUAL ACTIVITY [<i>Only ask if ≥ 18 years of age</i>]		
1. Which of the following best represents how you think of yourself? <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight, that is not lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else (specify): _____ <input type="checkbox"/> Unknown/I don't know <input type="checkbox"/> Refused/prefer not to answer		
2. Do you currently describe yourself as male, female, or transgender? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> None of these <input type="checkbox"/> Refused/prefer not to answer		
Yes	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently sexually active? (if no skip to question 4)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. If yes to question 3, since your illness started, have you had sexual contact with another person? Sexual contact would include genital sex, anal sex, oral sex, or any other sexual contact.		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. If yes to question 3, in the 7 days before your illness started, did you have sexual contact with another person? Sexual contact would include genital sex, anal sex, oral sex, or any other sexual contact.		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. If yes to question 3b, were your sex partners (select all that apply): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Another <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer Not to Answer		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. If yes to question 3b, in the 7 days before your illness started did any of your sex partners have diarrhea or symptoms similar to your own?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes to question 3b, read prompt. For the next questions I'm going to be more explicit about the kind of sex you had in the week before your illness started. This will help me to better understand how you could have become sick.		
iii. In the 7 days before your illness started, what kind of sexual contact did you have?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Genital sex (for example, penis in the vagina)?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Anal sex (for example, penis in the anus)?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Oral sex (for example, mouth on penis or vagina)?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Anilingus or rimming (meaning mouth on anus)?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Other sexual contact (for example touching your partner's anus with your hands, your partner touching your anus with their hands, or sharing of sex toys)?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. If yes to question 3b, in the 7 days before your illness started did you use drugs or alcohol during or immediately before sex? Some examples include alcohol, Viagra, meth, GHB, cocaine, or poppers. (specify): _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. In the 7 days before your illness, how many sex partners did you have? (specify): _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. If yes to question 3bv, were any of these partners new?		
a. If yes to question 3bv1, in the 7 days before your illness started, did you meet your new sex partner(s) at any of the following places?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Bar, restaurant or club? (specify): _____		

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ii. Bathhouse? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	iii. Bookstore? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	iv. Gym? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	v. Park? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vi. Social media sites? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vii. Dating or hookup sites? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	viii. Party, conference, or other type of event? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ix. Sex club or sex party? (specify): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	x. Other location I didn't ask about? (specify): _____
Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the <u>past 12 months</u> have you been told by a doctor that you have a sexually transmitted infection?
			a. If yes to question 4, which infection? (select all that apply) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Genital warts <input type="checkbox"/> Herpes <input type="checkbox"/> Other (specify): _____

Section 9: CLOSING

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. This is the end of the questionnaire. Thank you very much for your time.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Would you like any additional materials about <i>Shigella</i> or can I answer any questions for you?

Thank you for your time. Have a nice day.

[Conclude interview]