***EMERGE*ncy ID NET CRASHED Enrollment Data Form**

**Clinician questions:**

|  |
| --- |
| 1. Based on the participant’s history and physical, what is your clinical suspicion this participant has Mpox infection?

[ ]  Very Unlikely  [ ]  Unlikely  [ ]  Neutral  [ ]  Likely  [ ]  Very Likely1. Based on the participant’s history and physical, will you be obtaining a Mpox test as part of usual care?

[ ]  Yes [ ]  No 1. Rash/lesion description (check all that apply):

 [ ]  Vesicular  [ ]  Pustular  [ ]  Crusted  [ ]  Ulcerated 1. How many lesions are present?\_\_\_\_\_\_\_\_\_\_\_\_\_ # of lesions

 5. Is there lymphadenopathy? [ ]  Yes [ ]  No  6. Is there tenderness to palpation of rash/lesions? [ ]  Yes [ ]  No  7. Estimate the approximate diameter of a typical lesion: \_\_\_\_\_\_\_\_\_ cm  8. Estimate the approximate diameter of the largest lesion: \_\_\_\_\_\_\_\_\_\_ cm 9. Please circle location(s) of lesions: |

**Participant interview questions – administered by site coordinator**

*If interviewing parent/guardian, “your child” should be used instead of “you” or “your” in the questions below. Tell the participant that you will be asking some personal questions to help us understand more about this infection and if anything makes them uncomfortable and they would rather not respond to a question, they can tell you and you will move on.*

**Demographics:**

1. Age (in years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Ethnicity: [ ]  Hispanic or Latino [ ]  Non-Hispanic or Non-Latino
3. Race (*check one*):

|  |  |
| --- | --- |
| [ ]  | American Indian/Alaskan Native |
| [ ]  | Asian |
| [ ]  | Native Hawaiian or Pacific Islander |
| [ ]  | Black or African American |
| [ ]  | White |
| [ ]  | Other |
| [ ]  | Mixed Race (*Please elaborate in Comments*) |
| [ ]  | Declined to answer |

 12a. Comments on Race/ethnicity*:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What sex was originally listed on your birth certificate?

 [ ]  Female [ ]  Male [ ]  Decline to answer

1. What type of medical insurance do you have (*check all that apply*)?

 [ ]  Private (Blue cross, Healthnet, etc.)

 [ ]  Medi-Cal/Medi-caid

 [ ]  Medicare

 [ ]  My Health LA

 [ ]  Kaiser Permanente

 [ ]  Veteran Affairs

 [ ]  Tricare

 [ ]  Not insured

 [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Not sure what insurance I have

**Social History**

1. For the last ***three months***, have you had a stable place to live that you own, rent, or stay in as part of a household?

[ ]  Yes

[ ]  No

1. In the last ***three months***, where have you lived most of the time?

[ ]  House/Apartment/converted garage

[ ]  How many total rooms? (bedrooms, bathrooms, kitchen, living rooms, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  How many adults 18 and older live with you?: \_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  How many children 17 or younger live with you?: \_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Streets

[ ]  Homeless shelter

[ ]  Car/RV

[ ]  Motel/Hotels

[ ]  Staying with friends/family

[ ]  Skilled nursing facility

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your current job or occupation (*check all that apply*)?

 [ ]  Not in school (< 5 years old)

 [ ]  In school

 [ ]  Unemployed or Retired

 [ ]  Employed (specify type of employment):

 [ ]  Healthcare worker

 [ ]  Clinical/hospital laboratory worker

 [ ]  Work with animals (pets, rodents, etc.)

 [ ]  Prison worker

 [ ]  School or daycare worker

 [ ]  Cleaner of houses, buildings, hotels, restaurants

 [ ]  Food services

 [ ]  Other (specify occupation): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been in jail or prison in the ***last three months***?

[ ]  Yes

 [ ]  No

 [ ]  Not applicable (child)

 [ ]  Decline to answer

1. Have you travelled outside of this city in the ***last three months***?

 [ ]  Yes [ ]  No

19a. If Yes, specify location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Medical history**

1. Do you have diabetes: [ ] Yes [ ]  No

 20a. If Yes, do you use insulin? [ ] Yes [ ]  No

1. Do you have eczema or other chronic skin conditions? [ ] Yes [ ]  No
2. Do you have any immunocompromising conditions or conditions that affect your immune system? [ ] Yes [ ]  No

(*e.g. getting treated for rheumatoid arthritis, HIV/AIDS, cancer, etc*.)

1. Have you been diagnosed with a sexually transmitted disease/infection in the ***past year***?

 [ ]  Yes [ ]  No [ ]  Not applicable (child less than 16 years old)

23a. If Yes, please mark all that apply:

 [ ]  Chlamydia

 [ ]  Gonorrhea

 [ ]  Herpes

 [ ]  Syphilis

 [ ]  HIV

 [ ]  HPV (genital warts)

 [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Unsure

 [ ]  Decline to answer

1. Do you have HIV, the virus that causes AIDS?

 [ ]  Yes

 [ ]  No

 [ ]  Don’t know

 [ ]  Decline to answer

 [ ]  Not applicable (child)

 24a. If Yes, indicate most recent:

 [ ]  CD4 count if known: \_\_ \_\_ \_\_ \_\_ (Cells/mm3)

 [ ]  Viral load \_\_ \_\_ \_\_ \_\_ \_\_ (copies/mL)

 [ ]  Undetectable

 [ ]  Not sure/Declined

 24b. If Yes, are you taking HIV medications?

 [ ]  Yes

 [ ]  No

 [ ]  Don’t know

 [ ]  Decline to answer

1. Are you using medications to prevent an HIV infection, also known as PrEP (Pre-Exposure Prophylaxis)?

[ ]  Yes

[ ]  No

[ ]  Don’t know

[ ]  Decline to answer

[ ]  Not applicable (child)

1. Do you think you may be pregnant?

 [ ]  Yes

 [ ]  No/Not sure

 [ ]  Not applicable (male, child)

1. Have you received any of the following shots or vaccines:

27a. Smallpox (not chicken pox!) shot/vaccine : [ ]  Yes [ ]  No [ ]  Unsure

27b. Mpox or “monkeypox” shot/vaccine: [ ]  Yes [ ]  No

 27b1. If Yes, select below:

[ ]  Imvamune/JYNNEOS, dates of administration:

Dose 1: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 MM DD YYYY

Dose 2: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 MM DD YYYY

[ ]  Imvanex/ACAM2000, date of administration: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 MM DD YYYY

 [ ]  Unknown Mpox vaccine, date of administration: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 MM DD YYYY

1. Have you had prior Mpox (also known as Monkeypox) infection (positive Mpox test)? [ ] Yes [ ]  No

28a. If Yes, what was approximate date of diagnosis? \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 MM DD YYYY

**History of present illness**

|  |  |
| --- | --- |
| 1. Have you seen another health care provider (doctor) for your current symptoms *prior* to this visit?
 |   [ ]  Yes [ ]  No  |
|  *If Yes, answer 29a-d:*  29a. Where was the last place you got care  (*check one*)?   |   [ ]  Emergency Room  [ ]  Primary care doctor [ ]  STI/STD/HIV clinic [ ]  Planned Parenthood  [ ]  Dermatologist  [ ]  Urgent Care  [ ]  Telehealth/phone visit [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  29b. If Yes, did you have a rash at that time?  |  [ ]  Yes [ ]  No  |
|  29c. What was the diagnosis given at that time (*check all that apply*)? [ ]  Viral syndrome (cold/URI/influenza) [ ]  COVID-19 [ ]  Cellulitis  [ ]  Allergic reaction rash (contact dermatitis/insect bites, etc.)  [ ]  Shingles (Herpes zoster)  [ ]  UTI/prostatitis  [ ]  Gonorrhea, Chlamydia, Herpes, or other Sexually transmitted infection  [ ]  Unknown [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  29d. Was a medication prescribed?  | [ ]  Yes [ ]  No If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*If unknown, write “unknown”* |

1. How many days have you had your rash? \_\_\_\_\_\_\_\_\_\_\_ days
2. Have you had a fever in the ***last 2 weeks***?

(measured or subjective) [ ]  Yes [ ]  No/Not sure

1. Which of the following symptoms have you experienced besides rash during the current illness? (*Check all that apply*)

[ ]  Chills

 [ ]  Body aches or muscle aches

 [ ]  Feeling tiredness or fatigue

 [ ]  Headache

 [ ]  Stuffy or congested nose

 [ ]  Sore throat

 [ ]  Cough

 [ ]  Swollen glands in your neck, armpits, or groin area (private area)

[ ]  Discomfort or pain when you pee, or peeing more often than usual, or having a strong feeling of needing to pee?

 [ ]  Discomfort in your bottom area (butt) when going to bathroom to poop?

[ ]  Feeling like you need to go to the bathroom to poop a lot, even though you actually don’t need to go?

 [ ]  Liquid or fluid coming out of your bottom area (butt)

 [ ]  Liquid or fluid coming out of your vagina (more than normal) or penis

 [ ]  Pain or discomfort in your lower belly area

 [ ]  Pain or discomfort when you have sex (participants 16 and over only)

 [ ]  Other symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  None of the above

32a. If other symptoms besides rash reported above, how many days did they last *(Note: If multiple symptoms reported use the number of days for the symptom that lasted the longest. If no other symptoms reported, i.e., "none of the above", write “0”)*?

 \_\_\_\_\_\_\_\_\_\_\_\_ days

1. Is the rash painful? [ ]  Yes [ ]  No
2. Is the rash itchy? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| 1. Have you been around someone with similar symptoms or rash in the ***last one month***?
 | [ ]  Yes [ ]  No [ ]  Unsure  |
|  35a. If yes, who? (*Check all that apply*) |  [ ]  People you live with/Household members  [ ]  Intimate/sexual partners  [ ]  Coworkers  [ ]  Schoolmates/daycare/Boys and Girls club  [ ]  Sports team members/gym  [ ]  Caregiver  [ ]  Others at shelter, prison [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  35b. If people you live with/Household members, how many had symptoms?: |   [ ]  Adults > 18: \_\_\_\_\_\_\_\_ [ ]  Children < 18: \_\_\_\_\_\_ |
| 35c. If people you live with/Household members, have you shared any of the following (*check all that apply*): |  [ ]  Beds  [ ]  Sheets/blankets  [ ]  Towels  [ ]  Clothing items  [ ]  Bathrooms   |
| 1. Have you or your child attended a large music festival, or crowded social event in the **last one month?**
 |   [ ]  Yes [ ]  No  |

***Note for site coordinator:***

*If participant is 15 years or younger, they are done with the questionnaire. Thank them for their time and ask them if they have any feedback about the questions we asked them and note their response in the comments section below. If participant is 16 years or older, proceed to the self-administered survey and after they complete that survey ask them for feedback and note their response in the comments section below. Make sure to obtain swabs and images and record locations on next page.*

**For site coordinator to complete:**

*Two rash swabs and up to four digital pictures of the rash swab sites should be obtained from each participant. If there is only one lesion, obtain two swabs of the same lesion. If there is more than one lesion, obtain one swab each from two different lesions. Please keep track of what body location the two swabs and images are obtained and note them on the swab label* ***and*** *on this form below.*



|  |  |
| --- | --- |
| Were rash swabs obtained? |  [ ]  Yes [ ]  No *If No, explain in Comments section.**If Yes, Note rash location (use guide below) of the two swabs below. If only one lesion, write the same location in both spaces below.* *Location A\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Location B\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Were pictures obtained? |  [ ]  Yes [ ]  No *If No, explain in Comments section.**If Yes, Note rash location (use guide below) of the lesions photographed below. If only one lesion, leave Location B blank**Location A\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Location B\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**Comments:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Form Completed by MM DD YYYY