



Invasive Listeriosis Questionnaire

Case ID:

National ID:

Please complete questionnaire for all invasive listeriosis cases that meet the following case definition:

Clinical Evidence: Invasive clinical illness is characterized by meningitis or bacteremia. Infection during pregnancy may result in fetal loss through miscarriage, stillbirth, neonatal meningitis or bacteremia.

Laboratory Criteria for Diagnosis: Laboratory confirmation of infection with symptoms:

- isolation of *Listeria monocytogenes* from a normally sterile site (e.g., blood, cerebral spinal fluid, joint, pleural or pericardial fluid) OR
- in the setting of miscarriage or stillbirth, isolation of *L. monocytogenes* from placental or fetal tissue (including amniotic fluid and meconium)

For cases of *Listeria* in pregnant women or infants ≤1 month of age the MOTHER is the case.

Section 1. Interviewer Details:

Case Interviewed by: _____ Date of interview: d ____ / m ____ / y ____

Respondent was: case parent spouse caretaker other, specify: _____

Section 2. Case Information:

Black-out if sending to PHAC	Case Name: _____	Proxy Name: _____
	Address: _____	Home phone: _____
	Physician: _____	Work phone: _____
		Cell Phone: _____
	Physician Phone: _____	
Date of birth d ____ / m ____ / y ____ age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Health Unit/Authority: _____	Province: _____	

Is Listeria Case Associated with Pregnancy? (Illness in pregnant woman, fetus or neonate ≤ 1 month)

- Yes If yes, Skip to Section 4
- No If no, continue to Section 3
- Unknown If unknown, continue to Section 3

Section 3. Clinical Information: (Non-pregnant adults and children > 1 month of age)

Positive specimen type(s): <input type="checkbox"/> CSF <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other: _____		PFGE Patterns: _____	
Date reported to Health Authority: d ____ / m ____ / y ____		Date first positive specimen collected: d ____ / m ____ / y ____	
Date of onset of first symptom: d ____ / m ____ / y ____		Type of Illness: <input type="checkbox"/> Bacteremia/sepsis <input type="checkbox"/> Meningitis	
When did symptoms resolve (recovery date)? d ____ / m ____ / y ____		<input type="checkbox"/> UTI <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Still ill <input type="checkbox"/> Don't Know			
Symptoms:	Diarrhea* <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Headache <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Muscle aches	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Chills <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Asymptomatic	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
*3 or more loose stools in 24 hours		Other: _____	

Admitted to hospital because of the illness? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK *do not include individuals who visit an emergency room or outpatient clinic	Date of admission: d ____ / m ____ / y ____ Date of discharge: d ____ / m ____ / y ____ <input type="checkbox"/> Still hospitalized at time of interview
Case deceased? <input type="checkbox"/> Y <input type="checkbox"/> N Date of death: d ____ / m ____ / y ____ If yes, <i>Listeria</i> infection underlying/contributing cause of death? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, was determination based on death certificate? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Underlying conditions or medications that suppress the immune system (e.g. diabetes, cancer, steroids)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, specify:	
Proceed to Section 5. Exposure Sources	

Section 4. Clinical Information: (Pregnant woman, fetus or neonate ≤ 1 month)	Provincial Lab ID:
--	--------------------

Positive specimen type(s): <input type="checkbox"/> CSF (mother) <input type="checkbox"/> Blood (mother) <input type="checkbox"/> Other: _____ PFGE Patterns: _____ <input type="checkbox"/> CSF (neonate) <input type="checkbox"/> Blood (neonate)
--

Date reported to Health Authority: d ____ / m ____ / y ____	Date first positive specimen collected: d ____ / m ____ / y ____
---	--

Clinical Information on Mother

Date of onset of first symptom: d ____ / m ____ / y ____ When did symptoms resolve (recovery date)? d ____ / m ____ / y ____ <input type="checkbox"/> Still ill <input type="checkbox"/> Don't Know	Type of Illness: <input type="checkbox"/> Bacterimia/sepsis <input type="checkbox"/> Meningitis <input type="checkbox"/> UTI <input type="checkbox"/> None <input type="checkbox"/> Other: _____
---	--

Symptoms:	Diarrhea* <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Nausea <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Headache <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Muscle aches <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Fever <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Chills <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Asymptomatic <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
*3 or more loose stools in 24 hours		Other: _____

Admitted to hospital because of the illness? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK *do not include individuals who visit an emergency room or outpatient clinic	Date of admission: d ____ / m ____ / y ____ Date of discharge: d ____ / m ____ / y ____ <input type="checkbox"/> Still hospitalized at time of interview
--	--

Case deceased? <input type="checkbox"/> Y <input type="checkbox"/> N Date of death: d ____ / m ____ / y ____ If yes, <i>Listeria</i> infection underlying/contributing cause of death? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, was determination based on death certificate? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK

Underlying conditions or medications that suppress the immune system (e.g. diabetes, cancer, steroids)? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, specify:

Outcome of Pregnancy: <input type="checkbox"/> Still pregnant <input type="checkbox"/> Fetal death (miscarriage/stillbirth) <input type="checkbox"/> Induced abortion <input type="checkbox"/> Live birth No. weeks gestation _____ Date: d ____ / m ____ / y ____

Clinical Information on Neonate:	Age (at onset of illness) _____ days
---	--------------------------------------

Date of onset of first symptom: d ____ / m ____ / y ____ When did symptoms resolve (recovery date)? d ____ / m ____ / y ____ <input type="checkbox"/> Still ill <input type="checkbox"/> Don't Know	Type of Illness: <input type="checkbox"/> None <input type="checkbox"/> Meningitis <input type="checkbox"/> Bacteremia <input type="checkbox"/> Febrile Gastroenteritis <input type="checkbox"/> Other _____
---	--

Admitted to hospital because of the illness? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK *do not include individuals who visit an emergency room or outpatient clinic	Date of admission: d ____ / m ____ / y ____ Date of discharge: d ____ / m ____ / y ____ <input type="checkbox"/> Still hospitalized at time of interview
Neonate deceased? <input type="checkbox"/> Y <input type="checkbox"/> N Date of death: d ____ / m ____ / y ____ If yes, <i>Listeria</i> infection underlying/contributing cause of death? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, was determination based on death certificate? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	

Section 5. Exposure Sources:	
In the 4 weeks before onset of illness did you/case:	
Live in a residential institution ? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK (e.g. Nursing home, long term care facility, hospital, prison, boarding school, etc)	Institution type/name:
Travel? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If, yes: <input type="checkbox"/> Within Province/Territory <input type="checkbox"/> Other Province/Territory <input type="checkbox"/> Outside Canada Travel Destination (country/town/resort):	Departure: d ____ / m ____ / y ____ Return: d ____ / m ____ / y ____
Have any contact with <u>domestic</u> animals or animal waste (include reptiles, fish, birds, cats, dogs, pet waste etc): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, specify	
Have any contact with <u>non-domestic</u> animals or animal waste (include farm animals, wildlife, zoo animals, animal waste etc): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, specify	

Section 6. Home Food Purchase	
Where did you/case purchase food for home consumption in the last 4 weeks (include grocery stores, farmers markets, speciality stores, ethnic markets, food banks etc)?	
Store Name	Location/Address

Section 7. Eating places outside the home:		
In the 4 weeks prior to illness onset did you/case eat at a restaurant, fast food outlet, coffeeshop, cafeteria or social event? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		
Eating Place Name	Location	Date

Section 8. Special Diets:	
Are you/case a vegetarian? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Are you/ case allergic to any foods? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, specify which foods:
In the 4 weeks prior to illness, were you/case on a special or restricted diet? (e.g. diabetic diet, kosher, halal, etc) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes, describe:	

Section 9: Food History: Did you/case eat any of the following foods in the 4 weeks prior to illness onset?						
Instructions for interviewer: For each food item that the case consumed, ask follow up questions regarding the brand, location of purchase. Please read all response options to case in each category. In the event of a fetal death/ neonatal infection (<1 month of age), the MOTHER is the case; ask her about her food history during the 4 weeks before DELIVERY						
INSTRUCTIONS TO READ TO CASE: I am interested in the foods you ate during the 4 weeks before your illness onset date. I will be asking you questions about 4 weeks before this date , that is, from d___/m___/y___ through d___/m___/y___ . For each food item, please give me your best guess as to whether you ATE the food, you're not sure but you PROBABLY ate the food, or you DID NOT EAT the food. Please include foods eaten by themselves, as part of a sandwich, or as part of another food dish, including salads.						
*Prob (Probably Ate) = Case thinks he/she ate this food or case usually eats this food, but is unsure if eaten during time period in question						
**DK = Don't know if it was eaten during the time period in question						
	Yes	Prob*	No	DK**	Brand/Details	Where purchased or eaten:
DELI MEATS:						
Turkey deli meat <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Chicken deli meat <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Beef deli meat <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Ham deli meat <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Bologna <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pastrami <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Salami <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pepperoni <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other deli meat (e.g. corned beef, kielbasa, prosciutto, mortadella) specify: _____ <input type="checkbox"/> prepackaged <input type="checkbox"/> sliced at the deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Prepackaged sandwich (purchased from vending machine, cafeteria, gas station, grocery store etc.)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
OTHER MEATS:						
Cooked chicken eaten cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cooked ham eaten cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cooked turkey eaten cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cooked sausage eaten cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		

	Yes	Prob*	No	DK**	Brand/Details	Where purchased or eaten:
Cured or dried meat (e.g. parma ham, pepperettes)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pâté/meat spread (not canned)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Hot dogs						
If yes, heated before eating? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other, specify:						
CHEESE and DAIRY:						
Brie	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Camembert	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Blue cheese (e.g. roquefort, gorgonzola, stilton etc)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Feta	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Goat cheese	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cottage cheese	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Ricotta	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Mexican-style cheese (e.g. queso fresco, queso blanco)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other soft/semi-soft cheeses (e.g. Havarti, Bocconcini, Gouda) specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other cheese, all types specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Unpasteurized cheese specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Butter (not margarine)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Unpasteurized (raw) milk	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pasteurized milk specify (e.g. whole, skim, 1%, 2% flavoured):	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Ice cream (soft serve)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Ice cream (other)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Yogurt	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Sour Cream	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other, specify:						
SEAFOOD:						
Shrimp/Prawns (not heated before eating)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Mussels (not heated before eating)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Oysters (not heated before eating)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Crab (not heated before eating)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Imitation crab meat (not heated before eating)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Smoked or cured fish (not canned)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Raw fish (e.g. sushi)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other, specify:						

	Yes	Prob*	No	DK**	Brand/Details	Where purchased or eaten:
SALADS/DIPS:						
Potato salad <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pasta salad <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Tuna salad <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Bean salad <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cole slaw <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Seafood salad <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Hummus <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other salads/dips (e.g. chicken salad, egg salad, tabouli) specify: _____ <input type="checkbox"/> homemade <input type="checkbox"/> purchased	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
VEGETABLES:						
Alfalfa sprouts	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Bean sprouts	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Bagged chopped lettuce/salad mix	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Prepared green salad (purchased from grocery store, cafeteria)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Whole lettuce	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Fresh raw mushrooms	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Fresh Herbs (e.g. basil, cilantro, parsley)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other vegetables purchased pre-cut (e.g. diced onions) specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other, specify:						
FRUIT:						
Honeydew melon	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cantaloupe	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Watermelon	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Fresh pre-cut fruit (e.g. fruit salad)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Unpasteurized fruit/vegetable juice (eg fresh squeezed orange juice)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other specify:						

Comments (Attach additional pages if needed):

--