Project ID_____ (*assigned by site coordinator*)

*EMERGE*ncy ID NET CRASHED project
Participant Contact Form

Note: This form will remain at each site in a secure location only accessible to project staff. For some participants who prefer to complete their survey on an ipad or smart phone, their cell phone or email address will be entered onto the REDCap. Date of ED visit will also be entered onto REDCap so that age can be calculated. All other identifying information recorded on this form will not be entered onto the main project REDCap. At the end of the project after all data are cleaned, the project director will notify the site to destroy this form.

Last Name: _____

First Name: _____

Medical Record Number: _____

Home Address: _____

_____

Cell Phone: _____

Work Phone: _____

Email address: _____

Alternate Contact Name: _____

Alternate Contact Phone: _____

Alternate Contact Email: _____

Preferred Method of Contact: (*check all that apply*):	☐ Cell phone ☐ Work phone ☐ Email ☐ Text	**Preferred Language:**	☐ English ☐ Spanish	**Best time to contact:**	☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

Date of ED Visit ___ ___ - ___ ___ - ___ ___ ___ ___
month **day** **year**

Initials of person completing this form _____

Project ID_____ (*assigned by site coordinator*)

*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 Likely
2. Based on the participant's history and physical, will you be obtaining a Mpox test as part of usual care?
   - ☐ Yes
   - ☐ No
3. Rash/lesion description (check all that apply):
   - ☐ Vesicular
   - ☐ Pustular
   - ☐ Crusted
   - ☐ Ulcerative

4. How many lesions are present?_____ # of lesions

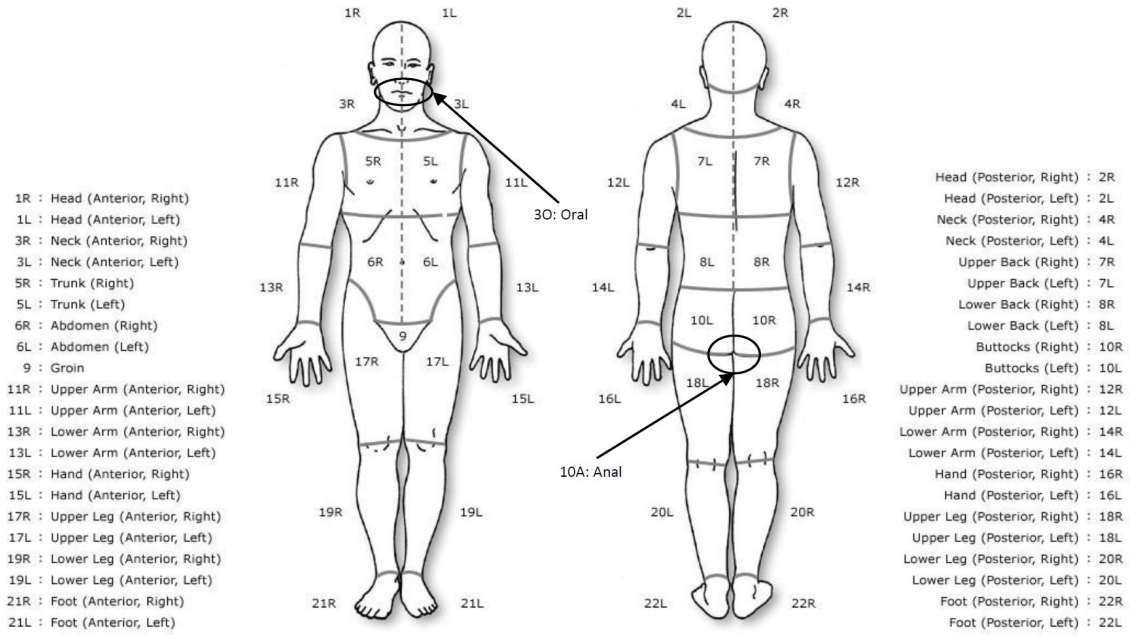
5. Is there lymphadenopathy? ☐ Yes ☐ No

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:



Project ID_____ (*assigned by site coordinator*)

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:

10. Age (in years) _____

11. Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

12. Race (*check one*):

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

12a. Comments on Race/ethnicity*:* _____

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

☐ Female ☐ Male ☐ Decline to answer

14. 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

15. 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

16. 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?: _____
        - ☐ How many children 17 or younger?: _____
    - ☐ Streets
    - ☐ Homeless shelter
    - ☐ Car/RV
    - ☐ Motel/Hotels
    - ☐ Staying with friends/family
    - ☐ Skilled nursing facility
    - ☐ Other: _____

17. What is your current 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): _____

18. Have you been incarcerated in the ***last three months***?
    - ☐ Yes
    - ☐ No
    - ☐ Not applicable (child)
    - ☐ Decline to answer

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

    ☐ Yes ☐ No

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

Medical history

20. Do you have diabetes: ☐Yes ☐ No
    20a. If Yes, do you use insulin? ☐Yes ☐ No

21. Do you have eczema or other chronic skin conditions? ☐Yes ☐ No

22. Do you have any immunocompromising conditions? ☐Yes ☐ No
(*e.g. getting treated for rheumatoid arthritis, HIV/AIDS, cancer, etc.*)

23. 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

24. Have you tested positive for HIV?
☐ 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

25. Are you using PrEP (Pre-Exposure Prophylaxis) to prevent HIV?
☐ Yes
☐ No
☐ Don't know
☐ Decline to answer
☐ Not applicable (child)

26. Do you think you may be pregnant?
    - ☐ Yes
    - ☐ No/Not sure
    - ☐ Not applicable (male, child)

27. Have you received any of the following vaccinations:

    27a. Smallpox vaccine : ☐ Yes ☐ No ☐ Unsure

    27b. Mpox or "monkeypox" 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

28. Have you had prior Mpox infection (positive Mpox test)? ☐Yes ☐ No

    28a. If Yes, what was approximate date of diagnosis? _____/_____/_____
                                                         MM DD YYYY

History of present illness

29. Have you seen another health care provider 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"

30. How many days have you had your rash? _____ days

31. Have you had a fever in the ***last 2 weeks***?
(measured or subjective) ☐ Yes ☐ No/Not sure

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

- ☐ Chills
- ☐ Body aches/backache
- ☐ Fatigue/tiredness
- ☐ Headache
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Cough
- ☐ Swollen lymph nodes (Lymphadenopathy)
- ☐ Urinary symptoms (dysuria, hematuria, urgency, frequency)
- ☐ Rectal pain/pain with defecation
- ☐ Feeling of frequently needing to pass stool, even though your bowels are empty(tenesmus)
- ☐ Discharge from anus
- ☐ Discharge from vagina/penis
- ☐ Pelvic pain
- ☐ Pain with intercourse (dyspareunia)
- ☐ Other:_____
- ☐ 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

33. Is the rash painful? ☐ Yes ☐ No

34. Is the rash itchy? ☐ Yes ☐ No

35. Have you had contact with someone with similar symptoms or rash in the ***last one month***? ☐ Yes ☐ No ☐ Unsure

35a. If yes, who? (*Check all that apply*)
- ☐ Household members
- ☐ Intimate partners
- ☐ Coworkers
- ☐ Schoolmates/daycare/Boys and Girls club
- ☐ Sports team members/gym
- ☐ Caregiver
- ☐ Others at shelter, prison
- ☐ Other: _____

35b. If Household members, how many had symptoms?:
- ☐ Adults ≥ 18: _____
- ☐ Children < 18: _____

35c. If Household members, have you shared any of the following (*check all that apply*):
- ☐ Beds
- ☐ Sheets/blankets
- ☐ Towels
- ☐ Clothing items
- ☐ Bathrooms

36. 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.

Project ID_____ (*assigned by site coordinator*)

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*_____

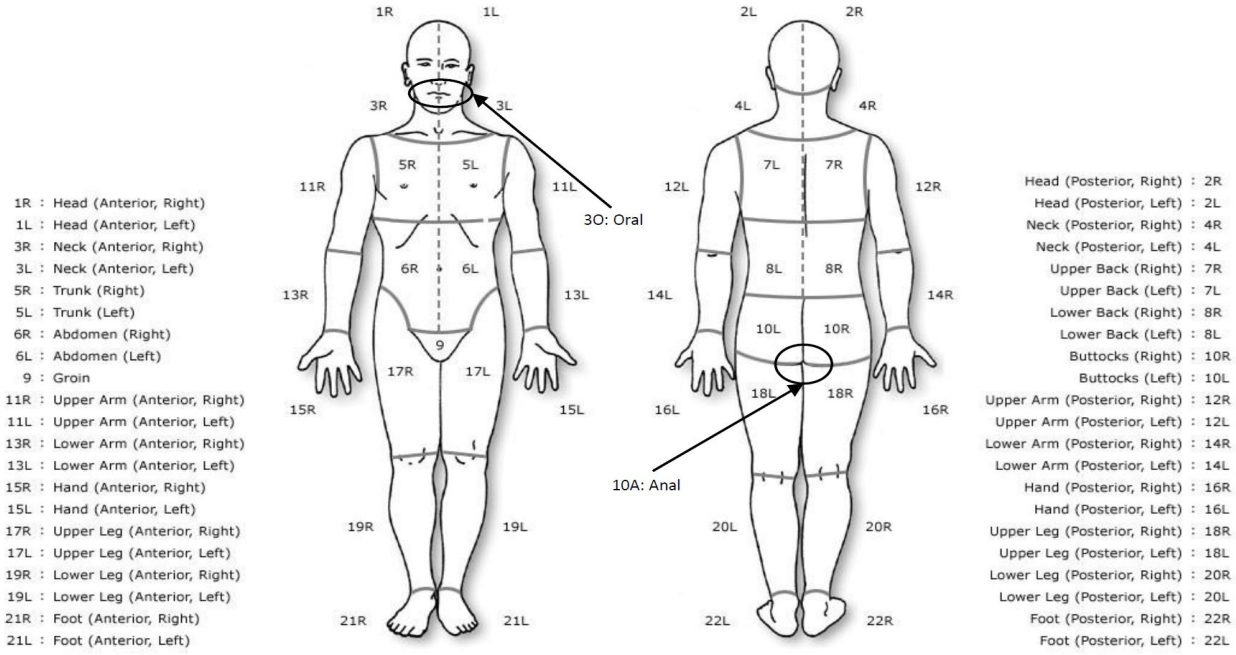
*Location B*_____

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*_____



Project ID_____ (*assigned by site coordinator*)

Comments:

_____
_____
_____

_____ _____/_____/_____
Form Completed by MM DD YYYY

Project ID_____

*EMERGE*ncy ID NET CRASHED Enrollment Survey

Instructions to site coordinator: This survey will be self-administered by participants 16 years of age or older. The site coordinator will ask the participant if they prefer to complete the survey on a tablet, their phone, or on paper and facilitate completion. Please remind the participant that they can skip any question they don't want to answer.

Instructions to participant: Please answer the questions below. All your answers will be kept confidential. You may skip any questions that you do not want to answer. You may ask the project coordinator for help at any time.

1. Do you identify as:
   - ☐ Male
   - ☐ Female
   - ☐ Non-binary
   - ☐ Transgender man/trans man
   - ☐ Transgender woman/trans woman
   - ☐ Genderqueer/gender nonconforming neither exclusively male nor female
   - ☐ Other: _____
   - ☐ Decline to answer

2. Do you identify as:
   - ☐ Straight or heterosexual
   - ☐ Lesbian or gay
   - ☐ Bisexual
   - ☐ Queer, pansexual, and/or questioning
   - ☐ Other: _____
   - ☐ Don't know
   - ☐ Decline to answer

3. In the ***last three months***, have you? *Please check all that apply*
   - ☐ Binged alcohol (5 drinks or more for men, 4 drinks or more for women on one occasion)
   - ☐ Used tobacco products (cigarettes, vape, chew etc.)
   - ☐ Used cannabis products
   - ☐ Injected any drugs
   - ☐ Used stimulants/uppers: Ecstasy, Molly, Ketamine, GHB, methamphetamine, cocaine, etc.
   - ☐ Used downers: Fentanyl, heroine, prescription opioid pills (Percocet, Vicodin, OxyContin, Methadone, Morphine, etc.)
   - ☐ Used "poppers"
   - ☐ None of the above
   - ☐ Decline to answer

Project ID_____

4. Do you live with a male who has sex with men OR do you live with a transgender person who has sex with men?
   ☐ Yes
   ☐ No
   ☐ Don't know
   ☐ Decline to answer

5. Have you engaged in any sexual activity in the ***last three months***?
   ☐ Yes
   ☐ No (*if no, survey is complete*)
   ☐ Decline to answer (*if decline, survey is complete*)

6. In the ***past three months***, how many sexual partners have you had?

   _____ number of partners

   ☐ Decline to answer

7. Have you had sexual relations with a partner who had similar symptoms (fevers, fatigue, etc.) and/or rash ***in the last one month***?
   ☐ Yes
   ☐ No
   ☐ Don't know
   ☐ Decline to answer

8. Do you have sex with:
   ☐ Men
   ☐ Women
   ☐ Both men and women
   ☐ Decline to answer

9. How often do you use the barrier method (e.g., condoms, dental dams) when engaging in sexual activity?
   ☐ Never
   ☐ Sometimes
   ☐ Always
   ☐ Decline to answer

10. Have you engaged in anal sex in the ***last three months?***
    ☐ Yes
    ☐ No
    ☐ Decline to answer

11. Have you engaged in oral sex in the last ***three months?***
    ☐ Yes
    ☐ No
    ☐ Decline to answer

Project ID_____

12. Sexual history for the last ***three months***, *please check all that apply*:
    - ☐ Have engaged in group sex (2 or more partners simultaneously)
    - ☐ Have taken part in sex parties
    - ☐ Have met sexual partners through dating apps (i.e.Tinder, Grindr, etc.)
    - ☐ Given someone money, drugs, or a place to stay for sex
    - ☐ Got paid for or traded sex for money, drugs, a place to stay, or gifts
    - ☐ Had sexual activity after taking drugs (chemsex or “Party ‘n Play”)
    - ☐ Had sexual activity at a music festival/rave
    - ☐ Had sexual activity with an anonymous partner(s)
    - ☐ Shared sex toys with a partner
    - ☐ Traveled to another country and engaged in sexual activity with a new partner
    - ☐ Had sex with someone visiting from another country
    - ☐ Had sex with someone visiting from out of town
    - ☐ None of the above
    - ☐ Decline to answer

Comments (*please use this space to provide any thoughts you would like to add or questions*)

_____
_____
_____
_____

Thank you for participating in this survey!

Project ID _____

*EMERGE*ncy ID NET CRASHED Project

Baseline Electronic Medical Record Review

Complete this form within 96 hours of enrollment. If participant was admitted to the hospital and is still in the hospital, please make sure to update the form (#4) when they are discharged home.

1. Did the participant receive an in-house (standard of care) monkeypox test? ☐ Yes ☐ No

   1a. If Yes, note result: ☐ Positive ☐ Negative/Indeterminate

2. Were any of the following STI tests performed in the ED or this hospital, if admitted? (*check all that apply; if Yes, indicate positive or negative/indeterminate*)

	No	**Yes**	**Positive**	**Negative/indeterminate**
Chlamydia	☐	☐	☐	☐
Gonorrhea	☐	☐	☐	☐
Syphilis	☐	☐	☐	☐
Herpes	☐	☐	☐	☐
HPV	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Trichomonas	☐	☐	☐	☐

3. Were any of the following medications given **while in the emergency department**?
   ☐ None of the following
   ☐ Antibiotics*: if antibiotics were given, please check below all that were administered*
      ☐ Clindamycin
      ☐ TMP/SMX
      ☐ Oxacillin/Nafcillin
      ☐ Doxycycline
      ☐ Piperacillin/Tazobactam
      ☐ Cephalexin
      ☐ Vancomycin
      ☐ Cefazolin
      ☐ Ceftriaxone
      ☐ Other (*specify*):_____
   ☐ Acyclovir/Valaciclovir
   ☐ Steroids (dexamethasone, methylprednisolone, prednisone, hydrocortisone, triamcinolone)
   ☐ Tecovirimat (TPOXX)

Project ID _____

4. Were medications prescribed upon discharge from the ED or hospital? ☐ Yes ☐ No

   4a. If Yes, please check all that apply:
   - ☐ Clindamycin
   - ☐ TMP/SMX
   - ☐ Doxycycline
   - ☐ Cephalexin
   - ☐ Steroids (either oral or topical)
   - ☐ Acyclovir/Valaciclovir
   - ☐ Tecovirimat (TPOXX)
   - ☐ Other (*specify*): _____

5. What was the ED discharge/admit diagnosis?
   (*check all that apply and if other conditions not listed below apply, then check "other" and list the one additional diagnosis*)?
   - ☐ Rash
   - ☐ Shingles
   - ☐ Herpes simplex
   - ☐ Contact dermatitis
   - ☐ Allergic reaction
   - ☐ Eczema
   - ☐ Hand, foot, mouth disease
   - ☐ Cellulitis
   - ☐ Arthropod bite (insect bite)
   - ☐ Scabies
   - ☐ URI/influenza/influenza-like illness/viral syndrome
   - ☐ MPox
   - ☐ Other (specify)_____

   Note: You do not need to record underlying conditions (e.g., diabetes, HTN)

6. ED Disposition
   - ☐ Discharged home from the ED
   - ☐ Discharged to skilled nursing facility
   - ☐ Discharged to self-care (street/homeless)
   - ☐ Discharged to shelter
   - ☐ Discharged to correctional facility (jail or prison)
   - ☐ Admitted to this hospital
   - ☐ Transferred to another hospital
   - ☐ Left against medical advice (AMA)

Project ID _____

Comments:

_____
_____
_____

_____ _____/_____/_____
Form Completed by MM DD YYYY

Project ID_____ (*assigned by project coordinator*)

*EMERGE*ncy ID NET CRASHED Project

TELEPHONE FOLLOW UP FORM

All participants should be called approximately 45 days (+/- 10 days) after enrollment. Please record all call attempts on a log. If unable to complete visit, please complete the first question on this form and note reason for missed visit. Please review the participant's enrollment form so you can prompt them for questions 2a (remind them of the number of days they reported having the rash at that time) and question 3. Questions 8-10 are for participants 16 years and older.

1. Telephone follow-up completed:
   ☐ Yes (Proceed to #2)
   ☐ Unable to complete follow-up

   1a. If unable to complete follow-up, specify reason:
   ☐ Participant illness or injury
   ☐ Participant refusal
   ☐ Scheduling difficulties
   ☐ Unable to contact
   ☐ Other (specify):_____

2. Did your initial *rash* (that you had when you went to the emergency room about 5 or 6 weeks ago) completely resolve?
   ☐ No
   ☐ Yes

   2a. If Yes, how many total days did you have that rash from start to finish?

   _____days

   2b. If No, how would you describe your current rash as compared to your initial emergency room visit?
   ☐ Improved
   ☐ Remains the same
   ☐ Worsened

3. Have your *other* (non-rash) initial symptoms completely resolved?
   ☐ No
   ☐ Yes
   ☐ Did not report other symptoms at enrollment

3a. If No, what symptoms are you still experiencing (*check all that apply*) ?

☐ Fever
☐ Chills
☐ Body aches/backache
☐ Fatigue/tiredness
☐ Headache
☐ Nasal congestion
☐ Sore throat
☐ Cough
☐ Swollen lymph nodes (Lymphadenopathy)
☐ Urinary symptoms (dysuria, hematuria, urgency, frequency)
☐ Rectal pain/pain with defecation
☐ Feeling of frequently needing to pass stool, even though your bowels are empty(tenesmus)
☐ Discharge from anus
☐ Discharge from vagina/penis
☐ Pelvic pain
☐ Pain with intercourse (dyspareunia)
☐ Other:_____

4. Did you develop another rash after your initial visit to the emergency department?
   ☐ No
   ☐ Yes

5. How many days total were you unable to do your normal daily activities due to your illness?
   _____ days

6. Since your initial visit, has anyone that you live with developed a similar infection?
   ☐ No
   ☐ Yes
   6a. If Yes, how many
   Adults?:_____ (18 and older)
   Children?:_____

7. Since your initial visit to the emergency department, have you had additional medical care for your symptoms?
   ☐ No
   ☐ Yes
   7a. If Yes, how many healthcare visits did you have for your illness? _____
   Note: If participant tested positive for Mpox and reported any health care visits, please complete a health care utilization form for each of the visits they report.
   7b. If Yes, did the doctor prescribe you some medicine?
   ☐ Yes, please specify: _____
   ☐ No

7c. If Yes, were you hospitalized for your illness?
☐ Yes
☐ No

7d. If Yes, did you have a positive Mpox test at any of these visits?
☐ Yes
☐ No/No test was done
☐ Don't know

The following questions are for participants 16 years or older:

8. Since the initial ER visit, have you received a vaccine for Mpox?
   ☐ No
   ☐ Yes
   8a. If Yes, please specify type of vaccine and when you got it:

   ☐ Imvanex/ACAM2000, date (mm/dd/yyyy)_____

   ☐ Imvamune/JYNNEOS, date: (mm/dd/yyyy)_____
   8a1. Was this your first dose or second dose?
   ☐ First dose
   ☐ Second dose
   ☐ Not sure which dose

   ☐ Unknown Mpox vaccine, date: (mm/dd/yyyy)_____

9. Since the initial ER visit, have you been diagnosed with a <u>new</u> sexually transmitted infection?
   ☐ No
   ☐ Yes
   9a. If Yes, please mark all that apply:
   ☐ Chlamydia
   ☐ Gonorrhea
   ☐ Herpes
   ☐ Syphilis
   ☐ HIV
   ☐ Other: _____
   ☐ Decline to answer

10. Since the initial ER visit, have any of your sexual contacts developed a similar infection?
    ☐ No sexual partners since initial visit
    ☐ No
    ☐ Yes
    10a. If Yes, how many?
    Women:_____
    Men:_____

Project ID_____ (*assigned by project coordinator*)

Comments:

_____
_____
_____

_____ _____/_____/_____
Form Completed by MM DD YYYY

Project ID_____ (*assigned by site coordinator*)

*EMERGE*ncy ID NET CRASHED Project

Test results and Follow-up Form

This form should be completed after the main site sends your participant's baseline Mpox test results and updated at 45 days. If participant tested positive for Mpox and reported symptoms at 45 days, please update this form again at 90 days.

1. Enrollment test Results *(check one box per row)*			**Test result**		
	Specimen not sent to lab	**Specimen not tested at lab**	**Indeterminate**	**Negative**	**Positive**
Location A:	☐	☐	☐	☐	☐
Location B:	☐	☐	☐	☐	☐

45-Day Follow-up – all participants

At approximately Day 45 after enrollment (+/- 10 days), review patient's EMR and conduct telephone follow-up and answer the following:

2. Did the participant receive an additional MPox test after enrollment and through the 45-day follow up?
   - ☐ No/No records available
   - ☐ Yes

     2a. If Yes, record result: ☐ Indeterminate ☐ Negative ☐ Positive

     If Yes, record location:_____

     Use enrollment form diagram, and if unknown location, write unknown

3. For participants with a positive Mpox test through 45 days, did the participant receive additional tests and/or health care visits related to their Mpox illness after enrollment?
   - ☐ Not applicable - participant does not have a positive Mpox test through Day 45
   - ☐ No/No records available
   - ☐ Yes

     3a. If Yes, how many total visits: _____

     Complete a healthcare utilization form for each visit

4. For participants with a positive Mpox test through 45 days, did the participant still report having symptoms?
   - ☐ Not applicable – participant does not have a positive Mpox test through Day 45
   - ☐ Telephone follow-up not done

☐ No
☐ Yes (If Yes, complete a 90 day follow-up telephone call and EMR review)

Note: If you checked "not applicable, "telephone follow-up not done," or "No" to #4, you are done with follow-up for this participant. You can check "not applicable" for #5 below.

90 day Follow-up

For participants with positive Mpox test who reported symptoms at 45 day phone follow-up (Yes to #4 above), at approximately 90 days (+/- 10 days) review patient's EMR, and call or text them to ask if they had additional health care visits related to their Mpox infection and answer the following:

5. Did the participant receive additional tests and/or health care visits after day 45?
   ☐ Not applicable
   ☐ No/No records available or unable to contact at 90 days
   ☐ Yes
      3a. If Yes, how many total visits: _____
      Complete a healthcare utilization form for each visit

Comments:
_____
_____
_____

_____ _____/_____/_____
Baseline completed by MM DD YYYY

_____ _____/_____/_____
45-day follow up completed by MM DD YYYY

_____ _____/_____/_____
90-day follow up completed by MM DD YYYY

Project ID_____ (*assigned by site coordinator*)

*EMERGE*ncy ID NET CRASHED Project

Health Care Utilization Form

*Complete this form for every **MPox-related health care visit** after enrollment for only for those with a positive Mpox test at any time during the project. If the participant received care at another facility, please attempt to retrieve their records and complete this form.*

1. Select visit type where care/tests were received:

   ☐ Emergency department
   ☐ Primary care
   ☐ STD clinic
   ☐ Dermatologist
   ☐ Urgent Care
   ☐ Other _____

2. Select the facility location:

   ☐ Enrollment Site (Project Site)
   ☐ Outside Facility, please specify name of facility: _____

3. Specify dates of care:

   Start date of care: __ __ / __ __ / __ __ __ __ mm/dd/yyyy

   End date of care: __ __ / __ __ / __ __ __ __ mm/dd/yyyy

4. Was the participant hospitalized at this visit?

   ☐ Yes
   ☐ No

5. Please specify reasons for visit (*mark all that apply*):

   ☐ Follow up visit, improving symptoms
   ☐ Pain at rash site
   ☐ Ongoing rash
   ☐ New rash at different site
   ☐ Skin infection (secondary SSTI)
   ☐ Sexually transmitted infection
   ☐ Fevers
   ☐ Fatigue/generalized weakness
   ☐ Body aches
   ☐ Swollen lymph nodes
   ☐ Headaches
   ☐ Pneumonia
   ☐ Eye infection

☐ Proctitis
☐ Dehydration
☐ Other:_____

6. Did the participant receive Mpox test at this visit? ☐ Yes ☐ No

6a. If Yes, note result: ☐ Positive ☐ Negative/Indeterminate

7. Were any of the following STI tests performed? (check all that apply; if Yes, indicate positive or negative/indeterminate)

	No	**Yes**	**Positive**	**Negative/indeterminate**
Chlamydia	☐	☐	☐	☐
Gonorrhea	☐	☐	☐	☐
Syphilis	☐	☐	☐	☐
Herpes	☐	☐	☐	☐
HPV	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Trichomonas	☐	☐	☐	☐

8. Were any of the following treatments provided? (check all that apply)
☐ None of the following
☐ Antibiotics: if Yes, please check all that apply:
☐ Clindamycin
☐ TMP/SMX
☐ Oxacillin/Nafcillin
☐ Doxycycline
☐ Piperacillin/Tazobactam
☐ Cephalexin
☐ Vancomycin
☐ Cefazolin
☐ Ceftriaxone
☐ Other (*specify*):_____
☐ Acyclovir/Valacyclovir
☐ Steroids (dexamethasone, methylprednisolone, prednisone, hydrocortisone, triamcinolone)
☐ Tecovirimat (TPOXX)

Project ID_____ (*assigned by site coordinator*)

9. What was the discharge/admit diagnosis?
   (*check all that apply and if other conditions not listed below apply, then check "other" and list the one additional diagnosis*)

   ☐ Rash
   ☐ Shingles
   ☐ Herpes simplex
   ☐ Contact dermatitis
   ☐ Allergic reaction
   ☐ Eczema
   ☐ Hand, foot, mouth disease
   ☐ Cellulitis
   ☐ Arthropod bite (insect bite)
   ☐ Scabies
   ☐ URI/influenza/influenza-like illness/viral syndrome
   ☐ MPox
   ☐ Other (specify)_____

   Note: You do not need to record underlying conditions (e.g., diabetes, HTN)

Comments:
_____
_____
_____

_____ _____/_____/_____
Form Completed by MM DD YYYY

Project ID_____ (*assigned by site coordinator*)

CRASHED Enrollment Form - Spanish

Clinician questions:

1. Based on the participant's history and physical, what is your clinical suspicion this participant has Monkeypox infection?
   - ☐ Very Unlikely
   - ☐ Unlikely
   - ☐ Neutral
   - ☐ Likely
   - ☐ Very Likely
2. Based on the participant's history and physical, will you be obtaining a Monkeypox test as part of usual care?
   - ☐ Yes
   - ☐ No
3. Rash/lesion description (check all that apply):
   - ☐ Vesicular
   - ☐ Pustular
   - ☐ Crusted
   - ☐ Ulcerative
4. How many lesions are present?_____ # of lesions

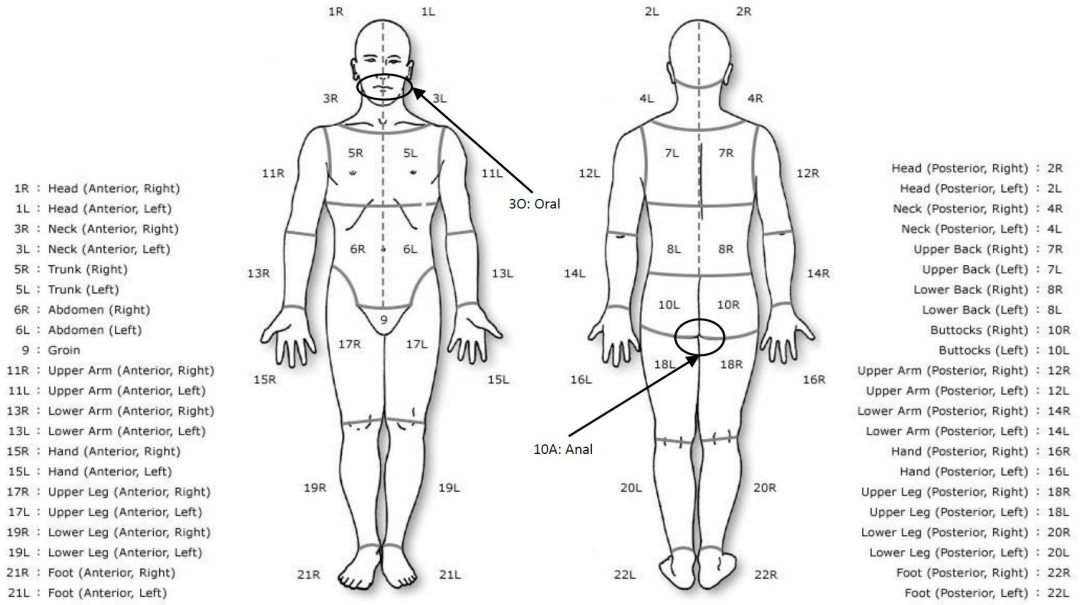
5. Is there lymphadenopathy? ☐ Yes ☐ No

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:



Project ID_____ (*assigned by site coordinator*)

Preguntas de la entrevista al participante – administradas por el coordinador del centro

Si se entrevista al padre/madre/tutor, debe utilizarse "su hijo/a" en lugar de "usted" o "su" en las preguntas a continuación. Dígale al participante que le haremos algunas preguntas personales para ayudarnos a entender más acerca de esta infección y si algo le hace sentir incómodo/a y preferiría no responder una pregunta, puede decírselo y usted avanzará a la siguiente pregunta.

Datos demográficos:

10. Edad en años _____

11. Etnia: ☐ Hispano o Latino ☐ No Hispano o No Latino

12. Raza (*marque una*):

    ☐ Indio americano/nativo de Alaska
    ☐ Asiático
    ☐ Nativo de Hawái o Isleño del Pacífico
    ☐ Negro o afroamericano
    ☐ Blanco
    ☐ Raza mixta (*proporcione detalles en comentarios*)
    ☐ Se rehusó a responder

    12a. Comentarios sobre raza/etnia*:* _____

13. ¿Qué sexo se indicó originalmente en su certificado de nacimiento?

    ☐ Femenino ☐ Masculino ☐ Se rehusó a responder

14. ¿Qué tipo de seguro médico tiene?
    ☐ Privado (Blue cross, Healthnet, etc.)
    ☐ Medi-Cal/Medi-caid
    ☐ Medicare
    ☐ My Health LA
    ☐ Kaiser Permanente
    ☐ Veteranos
    ☐ Tricare
    ☐ No está asegurado
    ☐ Otro: _____

Historia social

15. En los últimos ***tres meses***, ¿ha tenido un lugar estable para vivir del que usted fuera propietario, inquilino o se quedara como parte de un hogar?
    ☐ Sí
    ☐ No

Project ID_____ (*assigned by site coordinator*)

16. En los últimos ***tres meses***, ¿dónde vivió la mayor parte del tiempo?
    - ☐ Casa/apartamento/garaje convertido
        - ☐ ¿Cuántas habitaciones en total? (dormitorios, baños, cocina, sala de estar, etc.): _____
        - ☐ ¿Cuántos adultos de 18 años o más?: _____
        - ☐ ¿Cuántos niños/as de 17 años o menos?: _____
    - ☐ Calles
    - ☐ Refugio para personas sin hogar
    - ☐ Automóvil/vehículo recreativo (RV)
    - ☐ Motel/Hoteles
    - ☐ Permaneció con amigos/familia
    - ☐ Centro de enfermería especializada
    - ☐ Otro: _____

17. ¿Cuál es su ocupación actual?
    - ☐ No asiste a la escuela (< 5 años)
    - ☐ En la escuela
    - ☐ Desempleado o Jubilado(a)
    - ☐ Empleado:
        - ☐ Trabajador de atención médica
        - ☐ Trabajador de clínica/laboratorio de hospital
        - ☐ Trabajo con animales (mascotas, roedores, etc.)
        - ☐ Trabajador penitenciario
        - ☐ Trabajador escolar o de cuidado diurno
        - ☐ Limpieza de viviendas, edificios, hoteles, restaurantes
        - ☐ Servicios alimentarios
        - ☐ Otro (especifique la ocupación): _____

18. ¿Ha sido encarcelado en los últimos ***tres meses***?
    - ☐ Sí
    - ☐ No
    - ☐ No aplica (niño/a)
    - ☐ Se rehusó a responder

19. ¿Ha viajado fuera de esta ciudad en los últimos ***tres meses***?

    ☐ Sí ☐ No

    19a. Si la respuesta es sí, especifique el/los lugar(es): _____

Historial médico

20. ¿Tiene diabetes: ☐Sí ☐ No
    20a. Si la respuesta es sí, ¿utiliza insulina? ☐Sí ☐ No

21. ¿Tiene eczema u otra enfermedad cutánea crónica? ☐Sí ☐ No

Project ID_____ (*assigned by site coordinator*)

22. ¿Tiene alguna enfermedad inmunosupresora? ☐Sí ☐ No
(*p. ej., se está tratando por artritis reumatoide, VIH/SIDA, cáncer, etc.*)

23. ¿Le han diagnosticado una infección/enfermedad de transmisión sexual en el ***último año***?
☐ Sí ☐ No ☐ No aplica (niño/a menor de 16 años)

23a. Si la respuesta es sí, marque todas las que correspondan:
- ☐ Clamidia
- ☐ Gonorrea
- ☐ Herpes
- ☐ Sífilis
- ☐ VIH
- ☐ PVH (papilomavirus humano)
- ☐ Otro: _____
- ☐ No está seguro/a
- ☐ Se rehusó a responder

24. ¿El resultado de la prueba de VIH fue positiva?
- ☐ Sí
- ☐ No
- ☐ No sé
- ☐ Se rehusó a responder

24a. Si la respuesta es Sí, indique lo más reciente:
- ☐ Conteo de CD4, si se conoce: __ __ __ __ (células/mm3)
- ☐ Carga viral __ __ __ __ __ (copies/mL)
- ☐ Indetectable
- ☐ No está seguro/a/Se rehusó a responder

24b. Si la respuesta es Sí, ¿está tomando medicamentos para VIH?
- ☐ Sí
- ☐ No
- ☐ No sabe
- ☐ Se rehusó a responder

25. ¿Está utilizando PrEP (profilaxis previa a la exposición) para prevenir el VIH?
- ☐ Sí
- ☐ No
- ☐ No sabe
- ☐ Se rehusó a responder
- ☐ No aplica (niño/a)

26. ¿Piensa que puede estar embarazada?
- ☐ Sí
- ☐ No
- ☐ No aplica (varón, niño/a)

Project ID_____ (*assigned by site coordinator*)

27. ¿Ha recibido alguna de las siguientes vacunas?:

27a. Vacuna contra la viruela: ☐ Sí ☐ No ☐ No está seguro

27b. Vacuna contra "viruela símica" o Mpox (en inglés): ☐ Sí ☐ No

27b1. Si la respuesta es Sí, seleccione a continuación:

☐ Imvamune/JYNNEOS, fechas de administración:

Dosis 1: _____/_____/_____
MM DD AAAA

Dosis 2: _____/_____/_____
MM DD AAAA

☐ Imvanex/ACAM2000, fecha de administración: _____/_____/_____
MM DD AAAA

☐ Vacuna contra Mpox desconocida, fecha de administración: ____/____/_____
MM DD AAAA

28. ¿Ha tenido una infección por Mpox previa (resultado positivo de la prueba de Mpox)?

☐Sí ☐ No

28a. Si la respuesta es Sí, ¿cuál fue la fecha aproximada del diagnóstico? ____/____/____
MM DD AAAA

Historial de enfermedad actual

29. ¿Ha consultado a otro proveedor de atención médica para los síntomas actuales *antes* de esta visita? ☐ Sí ☐ No

Si la respuesta es Sí, responder 29a-d:

29a. ¿Cuál fue el último lugar donde se atendió (*marcar uno*)?

☐ Sala de emergencias
☐ Médico de atención primaria
☐ Clínica de ITS/ETS/VIH
☐ Paternidad planificada
☐ Dermatólogo
☐ Atención urgente
☐ Telesalud/consulta telefónica
☐ Otro: _____

29b. Si la respuesta es Sí, ¿tenía erupción en ese momento? ☐ Sí ☐ No

29c. ¿Cuál fue el diagnóstico que le dieron en ese momento?

- ☐ Síndrome viral (resfriado/infección vías respiratorias superiores (IVRS)/influenza))
- ☐ COVID-19
- ☐ Celulitis
- ☐ Erupción por reacción alérgica (dermatitis de contacto/picadura de insectos, etc.)
- ☐ Culebrilla (Herpes zóster)
- ☐ Infección del tracto urinario (ITU/prostatitis)
- ☐ Gonorrea, clamidia, herpes u otra infección de transmisión sexual
- ☐ Desconocido
- ☐ Otro: _____

29d. ¿Le recetaron un medicamento? ☐ Sí ☐ No

Si la respuesta es Sí, especifique:

_____

Si no lo conoce, escriba "no lo conoce"

30. ¿Cuántos días ha tenido la erupción? _____ días

31. ¿Ha tenido fiebre en las últimas ***2 semanas***?
(medida o subjetiva) ☐ Sí ☐ No/No está seguro

32. ¿Cuáles de los siguientes síntomas ha tenido además de la erupción de la actual enfermedad? (*Marque todas las opciones que correspondan*)

- ☐ Escalofríos
- ☐ Dolores corporales/dolor de espalda
- ☐ Fatiga/cansancio
- ☐ Dolor de cabeza
- ☐ Congestión nasal
- ☐ Dolor de garganta
- ☐ Tos
- ☐ Ganglios linfáticos inflamados (linfadenopatía)
- ☐ Síntomas urinarios (disuria, hematuria, urgencia, frecuencia)
- ☐ Dolor rectal/dolor al defecar
- ☐ Sentir la necesidad de evacuar los intestinos con frecuencia, a pesar de tener vacío el intestino (tenesmo)
- ☐ Secreción rectal
- ☐ Secreción vaginal/del pene
- ☐ Dolor pélvico
- ☐ Dolor al tener relaciones sexuales (dispareunia)
- ☐ Otro:_____
- ☐ Ninguno de los anteriores

32a. Si tuvo otros síntomas además de la erupción reportada anteriormente, ¿cuántos días duraron *(Note: si tuvo varios síntomas reportados, utiliza el número de días del síntoma que duró más tiempo. Si no se reportaron otros síntomas, i.e., "ninguno de los anteriores", escribe 0.*)?

Project ID_____ (*assigned by site coordinator*)

_____ dias

33. ¿La erupción es dolorosa? ☐ Sí ☐ No

34. ¿Es una erupción con comezón? ☐ Sí ☐ No

35. ¿Ha tenido contacto con alguien con síntomas similares o erupción en el último ***mes***? ☐ Sí ☐ No ☐ No está seguro

35a. Si la respuesta es Sí, ¿quién? (*Marque todas las opciones que correspondan*)

☐ Miembros del hogar
☐ Parejas afectivas
☐ Compañeros/as de trabajo
☐ Compañeros/as de escuela/cuidado diurno/club de niños y niñas
☐ Miembros equipo deportivo/gimnasio
☐ Cuidador/a
☐ Otros en refugio, prisión
☐ Otro: _____

35b. En el caso de los miembros del hogar, ¿cuántos tuvieron síntomas?:

☐ Adultos ≥ 18: _____
☐ Niños/as < 18: _____

35c. En el caso de los miembros del hogar, ¿ha compartido alguno de los siguientes elementos:

☐ Camas
☐ Sábanas/mantas
☐ Toallas
☐ Ropa
☐ Baños

36. ¿Ha usted o su hijo/a asistido a un festival de música masivo o evento social multitudinario en el último **mes?**

☐ Sí
☐ 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.

Project ID_____ (*assigned by site coordinator*)

For site coordinator to complete:

*Two rash swabs and 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*_____

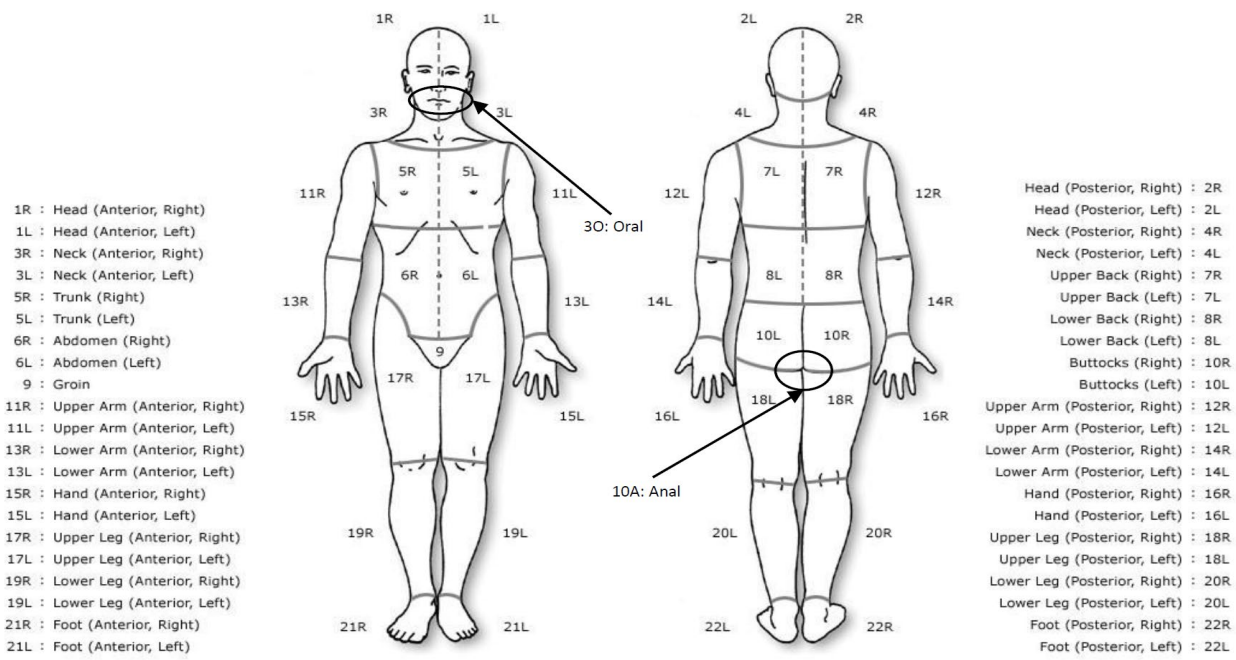
*Location B*_____

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*_____



Project ID_____ (*assigned by site coordinator*)

Comments:

_____
_____
_____

_____ _____/_____/_____
Form Completed by MM DD YYYY

ID del proyecto_____

Cuestionario del Proyecto *EMERGE*ncy ID NET CRASHED

Instrucciones para el coordinador del sitio: Este cuestionario será autoadministrado por los participantes de 16 años o más. El coordinador de la institución le preguntará al participante si prefiere completar el cuestionario en una tableta, en su teléfono o en papel y facilitará el proceso. Recuérdele al participante que puede saltear cualquier pregunta que no quiera responder.

Instrucciones para el participante: Responda las siguientes preguntas. Todas sus respuestas serán confidenciales. Puede saltearse cualquier pregunta que no quiera responder. Puede pedirle ayuda al coordinador del proyecto en cualquier momento.

1. Usted se identifica como:
   ☐ Masculino
   ☐ Femenina
   ☐ No binario
   ☐ Hombre transgénero
   ☐ Mujer transgénero
   ☐ Queer/no conforme con su género, ni mujer ni hombre exclusivamente
   ☐ Otro: _____
   ☐ Me niego a responder

2. Usted se identifica como:
   ☐ Heterosexual (persona que se siente atraída por personas del sexo opuesto)
   ☐ Lesbiana o gay
   ☐ Bisexual
   ☐ Queer, pansexual, y/o indeciso/a
   ☐ Otro: _____
   ☐ No lo sé
   ☐ Me niego a responder

3. Durante los ***últimos tres meses*** usted... marque todas las que correspondan
   ☐ ha bebido alcohol en exceso (5 bebidas o más para los hombres, 4 copas o más para las mujeres, en una ocasión)?
   ☐ ha consumido productos con tabaco (cigarrillos, dispositivos de vapeo, masticables, etc.)?
   ☐ ha consumido productos con cannabis (marijuana)?
   ☐ se ha inyectado alguna droga?
   ☐ ha usado estimulantes? Éxtasis, Molly, ketamina, GHB, metanfetamina, cocaína, etc.
   ☐ ha usado tranquilizantes? Fentanilo, heroína, píldoras opioides con prescripción (Percocet, Vicodin, OxyContin, metadona, morfina, etc.)
   ☐ ha usado “poppers”?
   ☐ Ninguna de las anteriores
   ☐ Me niego a responder

4. ¿Vive usted con un hombre que tenga sexo con hombres O vive usted con una persona transgénero que tenga sexo con hombres?

☐ Sí
☐ No
☐ No lo sé
☐ Me niego a responder

5. Durante los ***últimos tres meses***, ¿ha tenido relaciones sexuales?
   ☐ Sí (*si su respuesta es si, continúe con el cuestionario*)
   ☐ No (*si su respuesta es no, el cuestionario ha finalizado*)
   ☐ Me niego a responder *(si se niega, el cuestionario ha finalizado)*

6. En los ***últimos tres meses***, ¿cuántas parejas sexuales ha tenido?

   _____ número de parejas

   ☐ Me niego a responder

7. ¿Ha tenido relaciones sexuales con una pareja que haya tenido síntomas similares (fiebre, fatiga, etc.) y/o una erupción ***en el último mes***?
   ☐ Sí
   ☐ No
   ☐ No lo sé
   ☐ Me niego a responder

8. Usted tiene relaciones sexuales con:
   ☐ Hombres
   ☐ Mujeres
   ☐ Ambos
   ☐ Me niego a responder

9. ¿Con qué frecuencia usa un método de barrera (por ejemplo, condones, barrera bucal) al participar en actividades sexuales?
   ☐ Nunca
   ☐ A veces
   ☐ Siempre
   ☐ Me niego a responder

10. Durante los ***últimos tres meses***, ¿ha practicado sexo anal?
    ☐ Sí
    ☐ No
    ☐ Me niego a responder

11. Durante los ***últimos tres meses***, ¿ha practicado sexo oral?
    ☐ Sí
    ☐ No
    ☐ Me niego a responder

12. Por favor marque todas las que correspondan con su historia sexual de los últimos ***tres***

***meses**:*

☐ Participé en sexo grupal (2 o más parejas al mismo tiempo)
☐ Participé en fiestas sexuales
☐ Conocí parejas sexuales a través de aplicaciones de citas (por ejemplo, Tinder, Grindr, etc.)
☐ Le he dado a alguien dinero, drogas o un lugar donde quedarse a cambio de sexo
☐ Me pagaron o intercambié sexo por dinero, drogas, un lugar donde quedarme, o regalos
☐ Tuve relaciones sexuales luego de tomar drogas (chemsex o “Party ‘n Play”)
☐ Tuve relaciones sexuales en un festival de música o en una juerga
☐ Tuve relaciones sexuales con una pareja anónima
☐ Compartí juguetes sexuales con una pareja
☐ Viajé a otro país y tuve actividad sexual con una pareja nueva
☐ Tuve relaciones sexuales con alguien que venía de visita de otro país
☐ Tuve relaciones sexuales con alguien que venía de visita de otra ciudad
☐ Ninguna de las anteriores
☐ Me niego a responder

Comentarios (*use este espacio para proporcionar cualquier opinión que le gustaría añadir o para preguntas*)

_____
_____
_____
_____

¡Gracias por participar en este cuestionario!

Project ID _____ (*assigned by site coordinator*)

CRASHED Project

TELEPHONE FOLLOW UP FORM- SPANISH

All participants should be called approximately 45 days (+/- 10 days) after enrollment. Please record all call attempts on a log. If unable to complete visit, please complete the first question on this form and note reason for missed visit. ***Please review the participant's enrollment form*** *so you can prompt them for questions 2a (remind them of the number of days they reported having the rash at that time) and question 3. Questions 8-10 are for participants 16 years and older.*

1. Seguimiento telefónico completado:
   ☐ Sí (Continuar a #2)
   ☐ No fue posible completar el seguimiento

   1a. Si no fue posible completar el seguimiento, especifique el motivo:
   ☐ Enfermedad o lesión del participante
   ☐ Rechazo del participante
   ☐ Dificultad para programar la visita
   ☐ No fue posible comunicarse con el participante
   ☐ Otro motivo (especificar): _____

2. ¿Su *erupción* inicial (la que tuvo cuando vino a la sale de emergencias hace approximadamente 5 o 6 semanas) se resolvió por completo?
   ☐ No
   ☐ Sí

   2a. Si la respuesta es sí, en total, desde el principio hasta el final, ¿cuántos días tuvo la erupción? _____ días

   2b. Si la respuesta es no, ¿cómo describiría su erupción actual en comparación a su visita inicial a la sala de emergencias?
   ☐ Está mejor
   ☐ Permanece igual
   ☐ Está peor

3. ¿Sus *otros* síntomas iniciales (no la erupción) se han resuelto por completo?
   ☐ No
   ☐ Sí
   ☐ No tuve otros síntomas al momento de la inscripción (la visita inicial).

3a. Si la respuesta es no, ¿qué síntoma todavía está experimentando? *(marque todas las que correspondan)*

☐ Fiebre
☐ Escalofríos
☐ Dolor corporal/dolor de espalda
☐ Fatiga/cansancio
☐ Dolor de cabeza
☐ Congestión nasal
☐ Dolor de garganta
☐ Tos
☐ Inflamación de los nódulos linfáticos (adenopatía)
☐ Síntomas urinarios (disuria, hematuria, urgencia, frecuencia)
☐ Dolor rectal/dolor al momento de la defecación
☐ Sensación de necesidad de defecar frecuentemente, aunque sus intestinos estén vacíos (tenesmo)
☐ Descargas del ano
☐ Descargas de la vagina o del pene
☐ Dolor pélvico
☐ Dolor al tener relaciones sexuales (dispareunia)
☐ Otro: _____

4. ¿Desarrolló otra erupción luego de su visita inicial al departamento de emergencias?
   ☐ No
   ☐ Sí

5. ¿Cuántos días en total no pudo realizar sus actividades diarias normales debido a su enfermedad? _____ dias

6. Desde su visita inicial, ¿alguna de las personas con las que vive desarrolló una infección similar?
   ☐ No
   ☐ Sí
   6a. Si su respuesta es sí, ¿cuántos…
   Adultos?: _____ (18 años o más)
   Niños?: _____

7. Desde su visita inicial al departamento de emergencias, ¿ha recibido atención médica adicional por sus síntomas?
   ☐ No
   ☐ Sí
   7a. Si su respuesta es sí, ¿cuántas visitas de atención médica tuvo para tratar su enfermedad? _____
   Note: If participant tested positive for Mpox and reported any health care visits, please complete a health care utilization form for each of the visits they report.

7b. Si su respuesta es sí, ¿el médico le prescribió algún medicamento?
☐ Sí, especificar: _____
☐ No

7c. Si su respuesta es sí, ¿fue hospitalizado/a por su enfermedad?
☐ Sí
☐ No

7d. Si su respuesta es no, ¿tuvo un resultado positivo a una prueba de Mpox (Viruela del mono) en alguna de esas visitas?
☐ Sí
☐ No/No se realizó ninguna prueba
☐ No lo se

Las siguientes preguntas son para los participantes de 16 años o más:

8. Desde su visita inicial a la sala de emergencias, ¿ha recibido una vacuna contra la Mpox?
   ☐ No
   ☐ Sí

   8a. Si su respuesta es sí, ¿qué tipo de vacuna recibió y cuándo la recibió?

   ☐ Imvanex/ACAM2000, fecha (mm/dd/aaaa)_____

   ☐ Imvamune/JYNNEOS, fecha: (mm/dd/aaaa)_____

   8a1. ¿Esta fue la primera o la segunda dosis?
   ☐ Primera dosis
   ☐ Segunda dosis
   ☐ No estoy seguro/a de qué dosis fue

   ☐ No sé qué vacuna contra la Mpox recibí, fecha: (mm/dd/aaaa)_____

9. Desde su visita inicial a la sala de emergencias, ¿le han diagnosticado una <u>nueva</u> infección de transmisión sexual?
   ☐ No
   ☐ Sí

   9a. Si su respuesta es sí, marque todas las que correspondan:
   ☐ Clamidia
   ☐ Gonorrea
   ☐ Herpes
   ☐ Sífilis
   ☐ Gonorrea
   ☐ VIH
   ☐ Otra: _____
   ☐ Me niego a responder

10. Desde su visita inicial a la sala de emergencias, ¿sus parejas sexuales han desarrollado una infección similar?
    - ☐ No he tenido parejas sexuales desde la visita inicial
    - ☐ No
    - ☐ Sí
        - 10a. Si su respuesta es sí, ¿cuántos?
            - Mujeres: _____
            - Hombres: _____

Comentarios:

_____
_____
_____

_____ _____/_____/_____
Formulario completado por MM DD AAAA