

Interepidemic Rift Valley Fever Virus Seropositivity, Northeastern Kenya

Technical Appendix 1

Study participants received the following structured interview regarding housing, animal exposure, motor function, visual function, and recent or remote Rift Valley fever-related symptoms.

RVF Ijara Clinical Survey Form: PERSONAL DETAILS	
RVFID	<input type="text" value="13"/>
First Name	<input type="text"/>
Second Name	<input type="text"/>
Third Name	<input type="text"/>
Other name	<input type="text"/>
Head of Household	<input type="text"/>
Relationship to HH	<input type="text"/>
House Number	<input type="text" value="0"/>
Do you Sleep at this house?	<input checked="" type="checkbox"/>
Do you Stay at this house?	<input type="checkbox"/>
Village Number	<input type="text" value="0"/>
Date of Registration	<input type="text"/>
Year of Birth	<input type="text" value="0"/>
Sex	<input type="text" value="0"/>
Age	<input type="text" value="0"/>
Village	<input type="checkbox"/>
Nomadic	<input type="checkbox"/>
Assistant Information	
Name of Data Enterer	<input type="text"/>
Name of Data Collector	<input type="text"/>
Principal Investigators: Charles H. King and Eric Muchiri	

RVF Ijara Clinical Survey Form: EXPOSURES

RVFID

Data Collector Name

Data Entorer Name

Non-Animal Exposures

What type of settlement do you live in?

Was your home ever flooded?

When was it flooded?

Have you ever been displaced by a flood?

When were you displaced?

Do you use a mosquito net?

How often do you use the net?

Do you use fire?

How often do you use fire?

Do you use other forms of mosquito control?

Have you had a recent mosquito bite?

Have you had any personal illness?

When were you ill?

Have you had an ill family member?

When was your family member ill?

Have you had contact with a dead human body?

When was your contact with a dead body?

Animal Exposures

Please check any animal contact. Sheep contact Cow contact
Goat contact Camel contact

Have you sheltered livestock in your home?

camel sheep goat cow Other

Have you killed an animal?

camel sheep goat cow Other

Have you butchered an animal?

camel sheep goat cow Other

Have you skinned an animal?

camel sheep goat cow Other

Have you cooked with meat?

camel sheep goat cow Other

Have you milked an animal?

camel sheep goat cow Other

Have you ever drank raw animal milk?

camel sheep goat cow Other

Have you ever cared for birthing animal?

camel sheep goat cow Other

Have you ever disposed of an aborted animal fetus?

camel sheep goat cow Other

Symptoms **Have you ever had any of the following symptoms?**
If yes, please indicate when.

Fever <input type="checkbox"/> <input type="text"/>	Red eyes <input type="checkbox"/> <input type="text"/>	Hard to arouse <input type="checkbox"/> <input type="text"/>
Sick Feeling <input type="checkbox"/> <input type="text"/>	No appetite <input type="checkbox"/> <input type="text"/>	Coma <input type="checkbox"/> <input type="text"/>
Muscle aches <input type="checkbox"/> <input type="text"/>	Flushing <input type="checkbox"/> <input type="text"/>	Neck stiffness <input type="checkbox"/> <input type="text"/>
Chills <input type="checkbox"/> <input type="text"/>	Nausea <input type="checkbox"/> <input type="text"/>	Poor vision <input type="checkbox"/> <input type="text"/>
Backache <input type="checkbox"/> <input type="text"/>	Vomiting <input type="checkbox"/> <input type="text"/>	Nosebleeds <input type="checkbox"/> <input type="text"/>
Eye pain <input type="checkbox"/> <input type="text"/>	Painful eyes to light <input type="checkbox"/> <input type="text"/>	Vomiting Blood <input type="checkbox"/> <input type="text"/>
Headache <input type="checkbox"/> <input type="text"/>	Confusion <input type="checkbox"/> <input type="text"/>	Bloody stool <input type="checkbox"/> <input type="text"/>
Rash <input type="checkbox"/> <input type="text"/>	Spinning <input type="checkbox"/> <input type="text"/>	Bruising <input type="checkbox"/> <input type="text"/>

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RVF Ijara Clinical Survey Form: PHYSICAL EXAM

RVFID Weight Height

General Wasted

Head

Eyes

Scleral hemorrhages Scleral icterus

Ears

Nose

Throat

Neck

Normal movement

Chest

Heart

Murmur

Abdomen

Hepatomegaly Splenomegaly

GU

Neuro

Skin

Jaundice Petechiae Purpura Ecchymosis

Lymphadenopathy

Cervical Axillary Inguinal

Other

Name of Medical Doctor

Name of Data Enterer

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RVF Ijara Clinical Survey Form: OPHTHALMOLOGIC EXAM

RVFID

Visual Acuity-OS

Visual Acuity-OD

Anterior Chamber-OS

Anterior Chamber-OD

Anterior Uveitis-OS

Anterior Uveitis-OD

Posterior Chamber-OS

Posterior Chamber-OD

Vitreous reaction-OS

Vitreous reaction-OD

Retina-OS

Retina-OD

Retinitis-OS Macular-OS
Paramacular-OS

Retinitis-OD Macular-OD
Paramacular-OD

Retinal Hemorrhage-OS

Retinal Hemorrhage-OD

Zone-OS

Zone-OD

Area-OS

Area-OD

Optic disc edema-OS

Optic disc edema-OD

Retinal vasculitis-OS

Retinal vasculitis-OD

RVF Related Disease-OS

RVF Related Disease-OD

Comments

Ophthalmologist Name Data Enterer Name

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