



Acute Communicable Disease Control  
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## Meningococcal Case Risk Factor Assessment



To be filled out in conjunction with the  
Meningococcal Disease Case Report and Contact Roster

Interviewer Name (Print)	Interview Attempts Date/Time	Notes
	#1 / / : AM PM	
	#2 / / : AM PM	
	#3 / / : AM PM	

The Los Angeles County Department of Public Health (LAC DPH) is investigating cases of meningococcal infections. In order to understand why people are getting sick with this disease and how we can prevent its spread to others, I'd like to ask you some questions about you and your close friends' and family's habits, activities, and where you have visited or lived. This information will be kept private.

Patient Name (Last, First)

Age:

Primary Phone Number:

IRIS ID:

Is the interview being conducted with a proxy? Yes No

If yes, name and relationship to case:

Is there another person present during the interview? Yes No

If yes, name and relationship to case:

Occupation:

Place of Work:

Current Gender Identity:

☐ Male ☐ Female

☐ Transgender male/  
Trans Man

☐ Transgender female/  
Trans Woman

☐ Gender Non-Binary,  
Gender Non-conforming

☐ Another gender category/  
identity (specify)

☐ Prefer not to state

Race:

White

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

Other (specify)

Unknown

Prefer not to state

Ethnicity:

Hispanic/Latino

Non- Hispanic/Latino

Do you consider yourself to be:

Gay or Lesbian

Bisexual

Straight or Heterosexual

Not sure

Something else

Don't understand the question

Prefer not to state

What was your sex at birth?

Male

Female

Non-Binary or X

Other

Prefer not to state

## PAST MEDICAL HISTORY

Now, I will ask you some questions about your health. Let me assure you that this information will be kept private and will only be used to help us understand why people are getting sick with meningococcal disease.

1. Before you got sick, had you ever received meningococcal vaccine? ☐ Yes ☐ No ☐ Unknown

If yes, what year did you receive your last dose?

If no, why not?

- |   |   |
|---|---|
| <input type="checkbox"/> Didn't know about the vaccine              | <input type="checkbox"/> Don't have insurance/can't pay for it          |
| <input type="checkbox"/> Didn't think needed it/don't think at risk | <input type="checkbox"/> Afraid of side effects                         |
| <input type="checkbox"/> Don't know where to go                     | <input type="checkbox"/> Don't think it's effective/don't believe in it |

2. In the past 12 months, were you diagnosed with a sexually transmitted disease (STD)? ☐ Yes ☐ No ☐ Unknown

3. Have you ever been diagnosed with any of the following conditions?

- |                       |   |
|-----------------------|---|
| Chronic renal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                       |
| Cirrhosis             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                       |
| Diabetes              | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                       |
| Hepatitis             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify type: |
| HIV                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown                       |

Other immunocompromising conditions (e.g. cancer, lupus) ☐ Yes ☐ No ☐ Unknown

If Yes, in the last 1 year, did you take any of the following immunotherapy medications?

Approved complement inhibitors	Yes/No/Unknown
Eculizumab/Soliris	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Ravulizumab/Ultomiris	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pozelimab/Veopoz	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Avacincaptad pegol/Izervay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Zilucoplan/Zilbrysq	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Avacopan/Tavneos	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pegcetacoplan/Empaveli	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pegcetacoplan injection/Syfovre	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Iptacopan/Fabhalta	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cinryze	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Berinert	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Ruconest	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sutimlimab/Enjaymo	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

4. If you've had an HIV test in the past, what was the date of your last test?

5. Are you currently taking PrEP (Pre-exposure prophylaxis/Truvada?) Yes No Unknown

Reminder: For the following questions (except #9), ask the case to think back 3 months before the case symptom onset date,  
i.e. from        /        /        to        /        /

## ILL CONTACTS

6. 3 months before you got sick, do you remember spending time with a friend or relative or other individual with symptoms such as headaches, fever, problem in thinking, skin rash, nausea, vomiting?

Yes      No      Unknown

If Yes, provide details.

Name of Individual	Describe Relationship and Exposure	Location/Address Where Exposure Occurred	Phone

7. 3 months before you got sick, do you know anyone who was hospitalized with symptoms such as headaches, fever, problem in thinking, skin rash, nausea, vomiting?

Yes      No      Unknown

If Yes, provide details.

Name of Individual	Describe Relationship and Exposure	Name/Location of Hospital	Phone

## RESIDENCE/TRAVEL/SOCIAL ACTIVITIES

Now I'd like to ask you some questions about your living situation, where you have traveled recently, and where you like to hang out. I will ask similar questions about your friends and family with whom you spend a lot of time. These questions refer to activities occurring in the 3 months prior to your illness, so that would roughly be from xxx month to xxxx month. This will help us to know whether other people who have gotten sick have also spent time in these areas.

8. 3 months before you got sick, did you sleep in locations other than your primary residence at [FILL IN RESIDENCE]?

Yes      No      Unknown

If Yes, check all that apply. Specify location and length of stay for all selected.

Location	Name of Location/Address	Date(s) or Approximate Time
Dormitory		
Hotel/Hostel		
Jail/Prison		
Sheltered homeless (emergency shelter, transitional housing program, or safe haven)		
Homeless or transiently housed (e.g. living outdoors, sleeping in a car)		
Other (describe)		

9. One month before you got sick,

a) Did you travel **locally** (i.e. outside LA county but within the state of California)?

Yes

No

Unknown

If Yes, provide details on the table below.

b) Did you travel domestically (i.e. to another state)?

Yes

No

Unknown

If Yes, provide details on the table below.

c) Did you travel **internationally**?

Yes

No

Unknown

If Yes, provide details on the table below.

Travel Type	State	Country	Other Location Details (city, resort, pilgrimage, day trip, etc.)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
<input type="checkbox"/> Local <input type="checkbox"/> Domestic <input type="checkbox"/> International					
<input type="checkbox"/> Local <input type="checkbox"/> Domestic <input type="checkbox"/> International					
<input type="checkbox"/> Local <input type="checkbox"/> Domestic <input type="checkbox"/> International					

Did you travel with other people? —

Yes

No

Unknown

If Yes, who did you travel with?

Name	DOB	Relationship to You

I see you live in **[FILL IN THE CITY OF RESIDENCE]**.

10. In the last 3 months, in which other neighborhoods or cities did you spend your time besides **[FILL IN CITY]**?

Neighborhood/City	Date(s) or Approximate Time

11. What 3 bars/restaurants/clubs or hang out places did you go to most often?

Name	Address/Location	Date(s) or Approximate Time

12. How often did you attend social events outside of your home during the day or night in a typical week? These can include activities such as visiting bars, nightclubs, eating out at restaurants, or socializing anywhere with friends.

☐ 0 ☐ 1-2 ☐ 3-5 ☐ More than 5 ☐ Unknown

Describe:

13. Three months before you got sick, did you visit lesbian, gay, bisexual, transgender, and queer (LGBTQ) bars, clubs, or events?

☐ Yes ☐ No ☐ Unknown

If Yes, please answer the following:

a. How often did you attend such events or visit these places in the last 3 months?

☐ Once a month ☐ Once a week ☐ More than once a week ☐ Unknown

b. Name a few of the places or events that come to mind:

14. Three months before you got sick, did you attend any festivals, concerts, or other large events? (E.g. Sports events, Burning Man, Stage Coach, County Fairs, White Party, PRIDE, etc.)

☐ Yes ☐ No ☐ Unknown

If Yes, please tell me the most recent 3 events you attended.

Name	Address/Location	Date(s) or Approximate Time

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**SMOKING/DRUG USE**

Next, I will ask you questions about smoking and drug use, including illegal drugs. Again, this information will be kept private and will only be used to help us understand why people are getting sick with meningococcal disease. This information will not be used to harm you in any way and we appreciate your honesty with these questions.

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15. Think back to the 3 months before you got sick so that would be from roughly XXXX month – XXXX month, did you use *[Remind them if there was a large holiday in the timeframe of interest or to recall a special occasion they celebrated where they would've tried a new drug for the first time.]* (select all that apply):

Drug/Stimulant	Did you use?			If yes, how often?		If yes, did you share with others?		
Did you smoke and use drugs, including illegal drugs?	Yes	No	Unknown	Some days	Everyday	Yes	No	Unknown

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**SEXUAL PRACTICES [ASK IF >16 YEARS OLD]**

Next, I will be asking you questions about your sexual practices. Again, this information will be kept private and will only be used to help us understand why there is an increase in cases of meningococcal disease. Most of these questions refer to activities occurring in the 3 months prior to your illness, but can refer to other time periods. We really appreciate the information that you are providing.

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16. During the past 12 months, have you had sex with...?

Males only      Females only      Both males and females      Not sexually active      Unknown      Refused

**[QUESTIONS 17-18 REFER TO SEXUAL ACTIVITY IN PAST THREE MONTHS]**

17. Three months before you got sick how many partners did you have sex with?

18. Three months before you got sick, were any of your sexual or intimate partners anonymous?      Yes      No      Unknown

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**END OF SURVEY**

**Thank you for taking the time to speak with me today. Your participation helps us to stop others from becoming sick. As the situation develops, it is possible that I may need to contact you again for more information. We thank you for your ongoing support.**

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**ADDITIONAL NOTES:**