The California Department of Public Health (CDPH), Division of Communicable Disease Control (DCDC), requests your voluntary completion of this questionnaire regarding you and your baby who had infant botulism. This information is being collected by the CDPH/DCDC/Infant Botulism Treatment and Prevention Program (IBTPP), as mandated by Health and Safety Code Code § 123704, to investigate all cases of infant botulism to enable improved disease prevention and control. Dr. Stephen Arnon, Chief, IBTPP, is the CDPH official who is responsible for the information collected and who may be contacted regarding the location of the information and persons who use it, at 850 Marina Bay Parkway, Rm 361, Richmond, CA 94804, telephone 510-231-7600.

CA IB Number __ __ __ __ __	BIG ID _____	Toxin Type _____

First, I would like to remind you that:

- Your participation in this survey is voluntary and all information you share will be completely confidential
- This information is being collected by CDPH/DCDC/Infant Botulism Program to, as required by CA Health and Safety Code, investigate all cases of infant botulism to improve disease prevention and control
- If you have questions about the survey, location of the data, and persons who have access to it, please call us at 510-231-7600

To start, I would like to verify some information about your baby.

I. Patient Information:

Last Name _____ First Name _____

Date of Birth ___ / ___ / _____ (mm dd yyyy) Male ☐ Female ☐

Address at onset of illness_____
Number Street City State Zip

Home Phone # _____ Cell Phone # _____

Now I would like to ask you some questions about your pregnancy with *[infant's name]*.

II. Infant History

1. At which hospital was ***[infant's name]*** born?

_____
Hospital/Other City County State

2. How much did ***[infant's name]*** weigh at birth? _____lbs _____ozs

3. Was ***[infant's name]*** born
   - ☐1 at term (≥ 37 and ≤ 40 weeks gestation)
   - ☐2 preterm (< 37 weeks gestation)
   - ☐3 after term (> 40 weeks gestation)
   - ☐9 unknown

4. Was ***[infant's name]*** delivered
   - ☐1 vaginally
   - ☐2 by caesarian section

5. Did you receive prenatal care during your pregnancy? ☐0 No ☐1 Yes
   [If Yes,]
   a. In which trimester did your PN care begin?
      - ☐1 1st
      - ☐2 2nd
      - ☐3 3rd

6. While you were pregnant with ***[infant's name]*** did you ever smoke cigarettes?
   ☐0 No ☐1 Yes

   [If Yes,]
   a. How many cigarettes did you smoke per day? ***[read categories]***
      ☐1 < ½ pack per day
      ☐2 ½ pack per day
      ☐3 ½ - 1 pack per day
      ☐4 1-2 packs per day
      ☐5 >2 packs per day

7. After you gave birth to ***[infant's name]*** have you or anyone else in your household smoked cigarettes around the him/her?
   ☐0 No ☐1 Yes

   [If Yes,]
   a. How many cigarettes were smoked per day? ***[read categories]***
      ☐1 < ½ pack per day
      ☐2 ½ pack per day
      ☐3 ½ - 1 pack per day
      ☐4 1-2 packs per day
      ☐5 >2 packs per day

8. While you were pregnant with **[*infant's name]*** did you use marijuana, weed, or cannabis products in any way (like smoking, eating, or vaping)? ☐0 No ☐1 Yes

   [If Yes,]
   a. How many days per week, on average, did you use these products? _____
   b. How many times per day, on average, did you use these products? _____

9. After you gave birth to **[*infant's name]*** have you or anyone else in your household smoked/vaped marijuana around him/her ☐0 No ☐1 Yes

   [If Yes,]
   a. How many days per week, on average, did you/anyone in your household smoke/vape marijuana around **[*infant's name*]?** _____
   b. How many times per day, on average, did you/anyone in your household smoke/vape marijuana per day around **[*infant's name*]?**

10. How many children other than ***[infant's name]*** live in the house where he/she lives? _____

11. How many live births including ***[infant's name]*** have you had? _____

12. Is ***[infant's name]*** part of a multiple birth or multiple gestation? ☐0 No ☐1 Yes

Now I have a few questions about your baby's *habits* BEFORE he/she became sick with botulism.

13. Before ***[infant's name]*** became sick, did he/she usually go to bed with a pacifier?
    ☐0 No
    ☐1 Yes

14. When putting ***[infant's name]*** to sleep at night, did you usually place him/her
    ☐1 on his/her stomach
    ☐2 on his/her side
    ☐3 on his/her back
    ☐4 on his/her back and on his/her side

The next few questions focus on your infant's *health* BEFORE he/she became sick with botulism.

III. Infant's Recent Illness

15. Before your infant became ill, how many times *per week* did he/she normally have a bowel movement?
_____ per week

16. Did your baby have a change in bowel movement (BM) habits when he/she became ill?
☐0 No ***[If no, skip to question 16]***
☐1 Yes

17. How did it change?
☐1 Decrease in daily stool frequency
i. If yes, number of BMs per week _____
☐2 Increase in daily stool frequency
ii. If yes, number of BMs per week _____
☐3 Other _____

18. What was the date of your baby's last (non-suppository) BM before hospitalization? ___ / ___ / _____
mm dd yyyy

(*or* How many days had it been since your baby last had a BM when he/she was hospitalized? *Then calculate back from first hospitalization date.*)

18a. Date baby became constipated ___ / ___ / _____
mm dd yyyy
(Date baby became constipated = Date after last non-suppository BM if there were no BM for 3 or more days afterwards)

19. When did you first notice that your infant was ill? ___ / ___ / _____
mm dd yyyy

20. What were his/her symptoms before you took ***[infant's name]*** to the doctor?

☐ weak cry	☐ weak suck	☐ poor facial expression	☐ weak
☐ constipation	☐ difficulty swallowing	☐ difficulty feeding	☐ lethargic
☐ mom engorged breasts	☐ drooling	☐ droopy eyelids	☐ excessively fussy

21. When did you first contact a medical provider regarding these signs/symptoms?

___ / ___ / _____ ***[onset date]***
mm dd yyyy

Whom did you contact?

Name	Address	Telephone	Prescribed Treatments?

22. Is this your baby's regular pediatrician? ☐1 No ☐2 Yes
[If No,]
a. Who is your baby's regular pediatrician?

Name	Address	Telephone

23. At which hospital(s) was your infant treated?

Hospital Name	Address	Admit Date	Discharge Date
1.			
2.			
3.			

Now I have some questions about what types of foods your baby was eating BEFORE he/she became sick with botulism.

IV. Nutrition History

[If infant was 14 days old or younger at disease onset.]

24. What was your infant fed in the hospital after birth? ***[Read choices]***
    a. Mother's breast milk ☐0 No ☐1 Yes
    b. Formula ☐0 No ☐1 Yes
        i. Brand _____
    c. Sugar Water ☐0 No ☐1 Yes
    d. Water ☐0 No ☐1 Yes
    e. Other _____ ☐0 No ☐1 Yes

25. Before your baby became ill, had he/she ever been given breast milk? ☐0 No ☐1 Yes

26. Before your baby became ill, had he/she ever been given formula milk? ☐0 No ☐1 Yes

[If Yes,]

a. How many different brands (e.g. Enfamil, Similac, etc.) of formula has ***[infant's name]*** had? _____

b. How many different types (e.g. powdered, concentrate, Ready-to-Feed) of formula has ***[infant's name]*** had? _____

c. Which brands of formula have been given to ***[infant's name]***? ***[Check all that apply]***
    ☐1 Enfamil
    ☐2 Similac
    ☐3 Good Start
    ☐4 Other _____

d. Which brand of formula was given for the longest period of time?
    ☐1 Enfamil
    ☐2 Similac
    ☐3 Good Start
    ☐4 Other _____

e. What type of formula was this? ***[Read choices]***
    ☐1 Ready-to-Feed
    ☐2 Powdered
    ☐3 Concentrate

26 continued… Before your baby became ill…

f. Which brand of formula was given during the 4 weeks before ***[onset date]***?

- ☐ 1 Enfamil
- ☐ 2 Similac
- ☐ 3 Good Start
- ☐ 4 Other _____

g. What type of formula was this? ***[Read choices]***

- ☐ 1 Ready-to-Feed
- ☐ 2 Powdered
- ☐ 3 Concentrate

h. During the 4 weeks before ***[onset date]***, did the BRAND of formula being fed to ***[infant's name]*** change?

☐ 0 No ☐ 1 Yes

[If yes]

1. During which week did the change occur?
   - ☐ 1 1 week before ***[onset date]***
   - ☐ 2 2 weeks before ***[onset date]***
   - ☐ 3 3 weeks before ***[onset date]***
   - ☐ 4 4 weeks before ***[onset date]***

i. During the 4 weeks before ***[onset date]***, did the TYPE of formula being fed to ***[infant's name]*** change?

☐ 0 No ☐ 1 Yes

[If yes]

1. During which week did the change occur?
   - ☐ 1 1 week before ***[onset date]***
   - ☐ 2 2 weeks before ***[onset date]***
   - ☐ 3 3 weeks before ***[onset date]***
   - ☐ 4 4 weeks before ***[onset date]***

2. How did the type of formula change?
   - ☐ 1 From Concentrate to Powdered
   - ☐ 2 From Concentrate to RTF
   - ☐ 3 From RTF to Powdered
   - ☐ 4 From RTF to Concentrate
   - ☐ 5 From Powdered to RTF
   - ☐ 6 From Powdered to Concentrate

27. Since birth, would you say that your infant has been fed ***[Read choices]***:

- ☐ OB Only Breast Milk
- ☐ PB Primarily (2/3) Breast Milk
- ☐ OF Only Formula Milk
- ☐ PF Primarily (2/3) Formula Milk
- ☐ HH Half and Half

28. During the 4 weeks before ***[onset date]***, would you say that your infant was fed ***[Read choices]***:

- ☐ OB Only Breast Milk
- ☐ PB Primarily (2/3) Breast Milk
- ☐ OF Only Formula Milk
- ☐ PF Primarily (2/3) Formula Milk
- ☐ HH Half and Half

26a. Any breast milk at onset? ☐ 0 No ☐ 1 Yes
(If #26 = OB or PB, anyon = Y)

29. During the 4 weeks before ***[onset date]*** did your infant eat

a. Any CEREAL? ☐0 No ☐1 Yes
   [If Yes,]
   i. Was his/her first exposure to cereal during this time period? ☐0 No ☐1 Yes
   ii. Did he/she eat cereal 3 or more times during this time period? ☐0 No ☐1 Yes
   iii. What was the type and brand of the product?_____

b. Any OTHER NON-STERILE SOLIDS (NSS) (e.g. non jarred baby foods)? ☐0 No ☐1 Yes
   [If Yes,]
   i. Was his/her first exposure to this NSS during this time period? ☐0 No ☐1 Yes
   ii. Did he/she eat this NSS 3 or more times during this time period? ☐0 No ☐1 Yes
   iii. What was the type and brand of the product?_____

c. Any STERILE SOLIDS (SS) (e.g. jarred baby foods)? ☐0 No ☐1 Yes
   [If Yes,]
   i. Was his/her first exposure to this SS during this time period? ☐0 No ☐1 Yes
   ii. Did he/she eat this SS 3 or more times during this time period? ☐0 No ☐1 Yes
   iii. What was the type and brand of the product?_____

d. Any NON-STERILE LIQUIDS (NSL) (e.g. unpasteurized liquids)? ☐0 No ☐1 Yes
   [If Yes,]
   i. Was his/her first exposure to this NSL during this time period? ☐0 No ☐1 Yes
   ii. Did he/she have this NSL 3 or more times during this time period? ☐0 No ☐1 Yes
   iii. What was the type and brand of the product?_____

e. Any STERILE LIQUIDS (SL) (e.g. pasteurized liquids)? ☐0 No ☐1 Yes
   [If Yes,]
   i. Was his/her first exposure to this SL during this time period? ☐0 No ☐1 Yes
   ii. Was he/she given this SL 3 or more times during this time period? ☐0 No ☐1 Yes
   iii. What was the type and brand of the product?_____

f. Any BREWED TEA or TEA LEAVES? ☐0 No ☐1 Yes
   [If Yes,]
   i. Was his/her first exposure to tea during this time period? ☐0 No ☐1 Yes
   ii. Was he/she given tea 3 or more times during this time period? ☐0 No ☐1 Yes
   iii. Was this an herbal tea? ☐0 No ☐1 Yes
      [If Yes,]
      1. What was the type and brand of the tea?_____

29 continued… During the 4 weeks before [onset date] did your infant eat

g. Any HONEY? ☐0 No ☐1 Yes
[If Yes,]
i. Was his/her first exposure to honey during this time period? ☐0 No ☐1 Yes
ii. Was he/she given honey 3 or more times during this time period? ☐0 No ☐1 Yes
iii. What was the type and brand of the product?_____

h. Any CORN SYRUP (i.e. KARO SYRUP)? ☐0 No ☐1 Yes
[If Yes,]
i. Was his/her first exposure to karo syrup during this time period? ☐0 No ☐1 Yes
ii. Was he/she given karo syrup 3 or more times during this time period? ☐0 No ☐1 Yes
iii. What was the type and brand of the product?_____

i. Any OTHER HERBAL REMEDIES or HOMEOPATHIC PRODUCTS? ☐0 No ☐1 Yes
[If Yes,]
i. Was his/her first exposure to these items in this time period? ☐0 No ☐1 Yes
ii. Was he/she given these items 3 or more times in this time period? ☐0 No ☐1 Yes
iii. What was the type and brand of the product?_____

Next I have some questions about your infant's environment.

V. Environmental Exposures

30. During the 4 weeks before ***[onset date]***, did you or your spouse do any gardening or yard work with your baby present?
☐0 No ☐1 Yes

31. During the 4 weeks before ***[onset date]***, did any of the following events occur within one block of your home?
a. ☐0 No ☐1 Yes Construction of new homes or other buildings
b. ☐0 No ☐1 Yes Excavation/digging of new sewers or foundations
c. ☐0 No ☐1 Yes New road construction
d. ☐0 No ☐1 Yes Plowing of fields
e. ☐0 No ☐1 Yes Excessive dust in your neighborhood
f. ☐0 No ☐1 Yes Environmental change to your home such as remodeling or major landscaping
g. ☐0 No ☐1 Yes Other _____

32. During the 4 weeks before ***[onset date]***, were there any environmental disturbances (e.g. earthquake, strong winds, wildfires) in your area that resulted in a lot of dust being in the air?
☐0 No ☐1 Yes
Describe: _____

33. During the 4 weeks before ***[onset date]***, was your baby exposed to any large amounts of dust or dirt in the air at any other location or for any other reason you can recall?
☐0 No ☐1 Yes
Describe: _____

34. During the 4 weeks before ***[onset date]***, did your infant do any traveling (including, out of state?)
☐$_0$ No ☐$_1$ Yes

Describe: _____

35. During the 4 weeks before ***[onset date]***, did your infant visit a farm (e.g. pumpkin patch, petting zoo)?
☐$_0$ No ☐$_1$ Yes

Describe: _____

I have just a few more questions about your infant's health.

36. During the 4 weeks before ***[onset date]***, did your infant receive any antibiotics for any other illness?
☐$_0$ No ☐$_1$ Yes

[If yes,]
a. Name(s) of antibiotic(s) _____
b. Length of treatment (days) _____
c. Reason for antibiotic(s) _____

37. Has your ***[infant's name]*** received any immunizations? ☐$_0$ No ☐$_1$ Yes

If yes, complete DATES:

Required Vaccines	1st Dose	2nd Dose	3rd Dose	4th Dose
Polio (IPV)				
DTaP/Td/DT				
HBV (Hep B)				
HiB				
Rotavirus (RotaTeq)				
Pneumococcal (PCV)				
Possible	1st Dose	2nd Dose	3rd Dose	4th Dose
MMR				
Varicella				
Hep A				
Influenza				

Finally, I would like to verify some information about you and your baby's father/mother.

VI. Demographic Information

	Mother	**Father**
Name	_____ *Last, First*	_____ *Last, First*
38. Date of birth	___ / ___ / _____ mm dd yyyy	___ / ___ / _____ mm dd yyyy
39. Birthplace (state, country)	_____	_____
40. What is your and ***[infant's name's]*** father/mother occupation?	_____	_____
41. What is the highest level of education that you and ***[infant's name's]*** father/mother have completed?	☐$_{42}$ Less than high school ☐$_{67}$ High school graduate ☐$_{86}$ Some college ☐$_{93}$ College graduate ☐$_{98}$ Graduate school	☐$_{42}$ Less than high school ☐$_{67}$ High school graduate ☐$_{86}$ Some college ☐$_{93}$ College graduate ☐$_{98}$ Graduate school

42. a) What do you consider your and ***[infant's name's]*** father's/mother's race to be? ***[Do no read categories. Check the box or write whatever they respond]***

☐1 White	☐1 White
☐2 Black or African American	☐2 Black or African American
☐3 Asian, specify: _____	☐3 Asian, specify: _____
☐5 American Indian / Alaska native	☐5 American Indian / Alaska native
☐7 Native Hawaiian/Pacific Islander	☐7 Native Hawaiian/Pacific Islander
☐8 Multiple Race	☐5 Multiple Race
☐6 Other, specify: _____	☐6 Other, specify: _____
☐9 Unknown	☐9 Unknown

42. b) Are either of you of Hispanic origin or ethnicity?

☐0 Non-Hispanic	☐0 Non-Hispanic
☐1 Hispanic	☐1 Hispanic
☐9 Unknown	☐9 Unknown

43. What do you consider ***[infant's name]*** race to be?

☐1 White
☐2 Black
☐3 Asian, specify: _____
☐5 American Indian / Alaska native
☐7 Native Hawaiian/Pacific Islander
☐8 Multiple Race
☐6 Other , specify: _____
☐9 Unknown

44. Is ***[infant's name]*** of Hispanic origin or ethnicity?

☐0 No
☐1 Yes
☐9 Unknown

45. Does your infant live in a **[*read categories*]**

☐1 City or town (densely settled areas with a population of at least 1,000 people per square mile)
☐2 Suburban area (residential district located on the outskirts of a city)
☐3 Rural area, but not on a farm (sparsely populated areas with less than 1,000 persons per square mile)
☐4 On a farm

46. How would you categorize your total household income per year? **[*read categories*]**

☐1 $25,000 or less
☐2 Greater than $25,000 but less than $50,000
☐3 Greater than $50,000 but less than $100,000
☐4 Greater than $100,000 per year

47. Before your infant became ill, were you aware that honey should not be given to babies under 1 year of age?

☐0 No ☐1 Yes

[If Yes,]

a. To help us target this message to new parents, do you remember where you learned this?

_____

48. Did you receive names and phone numbers of other parents whose children have had infant botulism?

☐0 No ☐1 Yes

[If No,]

b. Would you like some? ☐0 No ☐1 Yes, please provide names

49. In the future, would it be OK if shared your contact information with families in your area that are newly diagnosed with infant botulism?

☐$_0$ No ☐$_1$ Yes, OK to release name and phone number

[If Yes,]

c. What is your email address? _____

50. We would like to be able to contact you in the future to share new information about infant botulism that our program may learn. Would it be ok if we contacted you by phone or mail in the future?

☐$_0$ No ☐$_1$ Yes

[If Yes,]

a. We have found that many young families move without providing a forwarding address. Do you have a family member that we could contact or send your mail to in the event that it was returned to us? ***[Suggest maternal and/or paternal grandparents of infant]***

Name	**Relationship**	**Address**	**Phone #**

Thank you very much for your time. Do you have any questions for me?

Date of Interview _____ Length of Interview __ __ hours __ __ minutes

Place of Interview __ phone ___ in person
Interviewee __ mother __ father __ mother and father __ other

Interviewer _____
Language _____ Translator _____