



Invasive Listeriosis Questionnaire	Provincial Case ID:
National Case ID (PHAC Only):	Provincial Lab 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: _____
		Work phone: _____
		Cell Phone: _____
	Physician: _____	Physician Phone: _____
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): CSF Blood Urine 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: Bacteremia/sepsis Meningitis

When did symptoms resolve (recovery date)? d ____ / m ____ / y ____ UTI Other: _____

Still ill Don't Know

Symptoms :	Diarrhea* <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Abdominal cramps <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Stiff neck <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	Confusion <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	Weakness <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	Nausea <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 (specify) _____



Hospitalization? *do not include individuals who visit an emergency room or outpatient clinic

Not admitted to hospital Admitted to hospital due to listeriosis Date of admission: d ____ / m ____ / y ____

Don't know Admitted to hospital for another reason Date of discharge: d ____ / m ____ / y ____

Still hospitalized at time of interview

Case deceased? Y N Date of death: d ____ / m ____ / y ____

If yes, *Listeria* infection underlying/contributing cause of death? Y N DK

If yes, was determination based on death certificate? Y N DK

Underlying medical conditions and treatments? Y N DK If yes, specify:

cancer organ transplant liver disease immunosuppressive medication

heart disease kidney disease COPD other (specify) _____

Proceed to Section 5. Exposure Sources

Section 4. Clinical Information: (Pregnant woman, fetus or neonate ≤ 1 month of age)

Positive specimen type(s): CSF (mother) Blood (mother) Other: _____ PFGE Patterns: _____

CSF (neonate) 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 ____ Type of Illness: Bacteremia/sepsis Meningitis

When did symptoms resolve (recovery date)? d ____ / m ____ / y ____ UTI None

Still ill Don't Know Other: _____

Symptoms :	Diarrhea*	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Abdominal cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Stiff neck	<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	Confusion	<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	Weakness	<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	Nausea	<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 (specify) _____

Hospitalization? *do not include individuals who visit an emergency room or outpatient clinic

Not admitted to hospital Admitted to hospital due to listeriosis Date of admission: d ____ / m ____ / y ____

Don't know Admitted to hospital for another reason Date of discharge: d ____ / m ____ / y ____

Still hospitalized at time of interview

Case deceased? Y N Date of death: d ____ / m ____ / y ____

If yes, *Listeria* infection underlying/contributing cause of death? Y N DK

If yes, was determination based on death certificate? Y N DK

Underlying medical conditions and treatments? Y N DK If yes, specify:

cancer organ transplant liver disease immunosuppressive medication

heart disease kidney disease COPD other (specify)? _____

Outcome of Pregnancy: Still pregnant Fetal death (miscarriage/stillbirth) Induced abortion 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 ____	Type of Illness: <input type="checkbox"/> None <input type="checkbox"/> Bacteremia <input type="checkbox"/> Meningitis <input type="checkbox"/> Febrile Gastroenteritis <input type="checkbox"/> Other _____
<input type="checkbox"/> Still ill <input type="checkbox"/> Don't Know		
Hospitalization? *do not include individuals who visit an emergency room or outpatient clinic		
<input type="checkbox"/> Not admitted to hospital	<input type="checkbox"/> Admitted to hospital due to listeriosis	Date of admission: d ____ / m ____ / y ____
<input type="checkbox"/> Don't know	<input type="checkbox"/> Admitted to hospital for another reason	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 ? Y N DK Institution type/name: _____
(e.g. Nursing home, long term care facility, hospital, convalescent care center, prison, boarding school, etc)

Travel? Y N DK Departure: d ____ / m ____ / y ____

If, yes: Within Province/Territory Other Province/Territory Outside Canada Return: d ____ / m ____ / y ____

Travel Destination (country/town/resort): _____

Section 6. Home Food Purchase – Please attach a separate sheet if necessary

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 – Please attach a separate sheet if necessary

In the 4 weeks prior to illness onset did you/case eat at a restaurant, fast food outlet, coffeeshop, cafeteria or social event? Y N DK

Eating Place Name	Location	Date

Section 8. Special Diets:

Are you/case a vegetarian? Y N DK

Are you/ case allergic to any foods? Y N 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) Y N 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 (e.g. roastbeef) <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 sandwiches/wraps (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:						
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		



	Yes	Prob*	No	DK**	Brand/Details	Where purchased or eaten:
Cured or dried meats (e.g. jerky, pepperettes) <input type="checkbox"/> prepackaged <input type="checkbox"/> unpackaged at deli counter	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Chicken eaten cold (e.g. chicken pieces or strips, rotisserie, leftover cooked chicken, cold chicken on salads) <input type="checkbox"/> purchased cooked, ready to eat <input type="checkbox"/> cooked at home & later ate it cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Ham eaten cold (not deli meat) <input type="checkbox"/> purchased cooked, ready to eat <input type="checkbox"/> cooked at home & later ate it cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Turkey eaten cold (e.g. turkey pieces or strips, leftover cooked turkey) <input type="checkbox"/> purchased cooked, ready to eat <input type="checkbox"/> cooked at home & later ate it cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Sausage eaten cold (e.g. ham sausage, breakfast sausage, frankfurters, cured sausages, leftovers) <input type="checkbox"/> purchased cooked, ready to eat <input type="checkbox"/> cooked at home & later ate it cold	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Ground Beef	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
CHEESE:						
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		
Mexican- or Latin-style fresh cheese (e.g. queso fresco, queso blanco, queso panela etc.)	<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) specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other cheese, all types (e.g. cottage cheese, ricotta, gouda, cheese sold as a block, Halloumi cheese) 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		
DAIRY:						
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/Frozen Yogurt/Gelato (including milkshakes, frozen dairy bars and sandwiches, and other novelties) If yes, was it soft serve from a machine? <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 Dairy (e.g. butter, yogurt, sour cream, whipped cream) specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
SEAFOOD:						
Raw fish (e.g. sushi, sashimi, tartar)	<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:
Smoked or cured fish (not from a can/retort pouch e.g. smoked salmon, gravlax, jerky or lox)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pre-cooked shrimp or prawns eaten cold (e.g. shrimp ring, shrimp cocktail, in a salad, leftovers eaten cold)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Pre-cooked crab eaten cold (including imitation crab meat)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Other ready to eat shellfish eaten cold (e.g. mussels, oysters, clams)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
SALADS & DIPS:						
Prepared green salad (e.g. garden, greek, caesar, purchased in a store, restaurant or cafeteria)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
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		
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		
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, tuna salad, seafood salad, rice 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		
FRESH VEGETABLES (EATEN RAW, UNCOOKED):						
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		
Lettuce and/or salad purchased pre-packaged in a bag or plastic container	<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		
Spinach, purchased loose or in a package	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Mushrooms (raw, uncooked)	<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		
Packaged pre-cut vegetables (e.g. in a platter or tray, diced onions, diced celery etc) specify: _____	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
FRESH FRUIT:						
Honeydew melon <input type="checkbox"/> whole, cut at home <input type="checkbox"/> pre-cut	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Cantaloupe <input type="checkbox"/> whole, cut at home <input type="checkbox"/> pre-cut	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Watermelon <input type="checkbox"/> whole, cut at home <input type="checkbox"/> pre-cut	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Packaged pre-cut fruit (e.g. in a platter or tray, apple slices, fruit salad etc)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		
Unpasteurized fruit/vegetable juice (e.g. fresh squeezed orange juice)	<input type="checkbox"/> Y	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> DK		



Local/Provincial/Territorial Comments (Attach additional pages if needed):

PHAC Comments (Attach additional pages if needed):