Attachment 5: Health Questionnaire

Form Approved
OMB No. 0920-0888
Exp. Date xx/xx/20xx

Health Questionnaire for study "Factors Influencing the Transmission of Influenza"

Name: Record Number:

Age: Gender: M F Height: Weight:

1. Do you have any respiratory illness such as severe asthma, COPD or tuberculosis?	YES	NO
2. Besides the flu, do you have any other serious illnesses such as diabetes or heart disease?	YES	NO
3. During this study, you will be asked to inhale deeply and cough hard several times. Do you have any condition or illness that would make it difficult or uncomfortable for you to do this?	YES	NO
4. If female, are you pregnant?	YES	NO

(Note: If the participant answers "yes" to any of the questions 1-4, they cannot participate in the study)

5. Do you have any of the following symptoms? (Circle all that apply)

Fever/chills	Headache	Fatigue	Cough	Sore throat
Sinus congestion	Runny nose	Sneezing	Muscle aches	

If YES, when did your symptoms begin?

6. Were you vaccinated against the flu in the past 6 months? YES NO

7. Have you taken any medication for the flu today, such as acetaminophen (Tylenol) or Oseltamivir (Tamiflu)?
YES NO If so, what did you take and when?

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this

If YES, how often do you smoke?		
9. Oral temperature (°C)		