Public reporting burden for this form is estimated to average 10 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 burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-XXXX). Do not return the completed form to this address.

Form Approved

OMB Number 0925-XXXX

Exp. Date: XX/XX/XXX

Study ID: __ __ __ __ __ __ __ __ __ __

CEIRS Human Influenza Surveillance Study

Form 5A: Current Symptoms

1. Is this subject considered to be exhibiting influenza like illness (ILI)?

   ☐ No ☐ Yes ☐ Unknown

2. If Yes, date of illness onset? __ __ / __ __ / __ __ __ __ (Note: must be within 7 days of ED presentation)

3. How many days has the subject had symptoms for? _____ days
   (Note: asymptomatic subject should be 0 days of ED presentation)

4. Ask the subject to think about their symptoms within the past 7 days. Have they experienced any:

a.	Cough?	☐ No ☐ Yes ☐ Unknown
i.	If Yes, did they cough up sputum?	☐ No ☐ Yes ☐ Unknown
b.	Shortness of breath?	☐ No ☐ Yes ☐ Unknown
c.	Sinus pain?	☐ No ☐ Yes ☐ Unknown
d.	Nasal congestion/rhinorrhea?	☐ No ☐ Yes ☐ Unknown
e.	Wheezing?	☐ No ☐ Yes ☐ Unknown
f.	Sore throat?	☐ No ☐ Yes ☐ Unknown
g.	Fever?	☐ No ☐ Yes ☐ Unknown
i.	If Yes, was it recorded?	☐ No ☐ Yes ☐ Unknown
ii.	If recorded, the temperature was: _____ C	
h.	Fatigue?	☐ No ☐ Yes ☐ Unknown
i.	If Yes, have they been able to get out of bed?	☐ No ☐ Yes ☐ Unknown
i.	Chest pain?	☐ No ☐ Yes ☐ Unknown
i.	If Yes, does their chest hurt when they breathe?	☐ No ☐ Yes ☐ Unknown
j.	Chills?	☐ No ☐ Yes ☐ Unknown
k.	Body aches?	☐ No ☐ Yes ☐ Unknown
l.	Headache?	☐ No ☐ Yes ☐ Unknown
m.	Loss of appetite?	☐ No ☐ Yes ☐ Unknown
n.	Nausea/Vomiting?	☐ No ☐ Yes ☐ Unknown
o.	Diarrhea?	☐ No ☐ Yes ☐ Unknown
p.	Stomach pain?	☐ No ☐ Yes ☐ Unknown
q.	Conjunctivitis?	☐ No ☐ Yes ☐ Unknown
r.	Other symptoms?	☐ No ☐ Yes ☐ Unknown
i.	If Yes, specify other symptoms:_____	