

Date:  $\frac{\quad}{D} \frac{\quad}{D} / \frac{\quad}{M} \frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$ **ZEN Colombia – Infant Symptoms Questionnaire**

1. In the past 2 weeks, has your baby had any of the following symptoms?

Fever	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Rash (not a diaper rash)	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Red eyes lasting more than a couple hours	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>	<input type="checkbox"/> <sub>88</sub> <i>Refused</i>

**If the respondent answered YES to any of the symptoms above, continue. If not, go to Question 5.**

2. If YES to fever, ask:

2a. When your baby had a fever, what was the highest temperature he/she had?

\_\_\_\_\_ degrees <sub>1</sub> Celsius <sub>2</sub> Fahrenheit <sub>777</sub> *Don't know* <sub>888</sub> *Refused*<sub>1</sub> Auxillary <sub>2</sub> Rectal

2b. When did you first notice the fever?

 $\frac{\quad}{D} \frac{\quad}{D} / \frac{\quad}{M} \frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$  <sub>777</sub> *Don't know* <sub>888</sub> *Refused*

2c. How many days did it last?

\_\_\_\_\_ days <sub>666</sub> Still ongoing <sub>777</sub> *Don't know* <sub>888</sub> *Refused*

3. If YES to rash, ask:

3a. When your baby had a rash, did it seem itchy?

<sub>0</sub> No <sub>1</sub> Yes <sub>777</sub> *Don't know* <sub>888</sub> *Refused*

3b. Was the rash bumpy?

<sub>0</sub> No <sub>1</sub> Yes <sub>777</sub> *Don't know* <sub>888</sub> *Refused*

3c. Where was the rash? (Choose all that apply)

<sub>1</sub> Face <sub>2</sub> Neck <sub>3</sub> Chest <sub>4</sub> Stomach <sub>5</sub> Arms <sub>6</sub> Hands  
<sub>7</sub> Back <sub>8</sub> Legs <sub>9</sub> Feet <sub>777</sub> *Don't know* <sub>888</sub> *Refused*

3d. When did you first notice the rash?

 $\frac{\quad}{D} \frac{\quad}{D} / \frac{\quad}{M} \frac{\quad}{M} \frac{\quad}{M} / \frac{\quad}{Y} \frac{\quad}{Y}$  <sub>777</sub> *Don't know* <sub>888</sub> *Refused*

3e. How many days did it last?

\_\_\_\_\_ days    <sub>666</sub> Still ongoing    <sub>777</sub> Don't know    <sub>888</sub> Refused

4. If YES to red eyes, ask:

4a. Were both eyes red or just one?

<sub>2</sub> Both    <sub>1</sub> Only one    <sub>777</sub> Don't know    <sub>888</sub> Refused

4b. Was there any discharge? (Fluid or pus coming from the eye)

<sub>0</sub> No    <sub>1</sub> Yes    <sub>777</sub> Don't know    <sub>888</sub> Refused

4c. When did you first notice your baby's eyes were red?

   /   /       <sub>777</sub> Don't know    <sub>888</sub> Refused  
D D M M M Y Y

4d. How many days did it last?

\_\_\_\_\_ days    <sub>666</sub> Still ongoing    <sub>777</sub> Don't know    <sub>888</sub> Refused

5. In the past 2 weeks, did your baby have any of the following symptoms:

Vomiting	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Coughing	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Sneezing	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Runny nose	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Swollen lymph nodes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Sleeping more than usual	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Not feeding as much as usual	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Skin redness without a rash	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
More irritable or crying more than usual	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Blood in the urine	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused
Nosebleeds	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>77</sub> Don't know	<input type="checkbox"/> <sub>88</sub> Refused

6. In the past 2 weeks, did your baby have any other unusual symptoms you would like to tell me about?

a. \_\_\_\_\_

b. \_\_\_\_\_