

STUDY ID: _____ - ____ - _____

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

Date: ____ / ____ / ____

D D M M M Y Y Y Y

Staff Administered: _____

ADULT Symptoms Questionnaire

City: _____

Clinic: _____

- ❖ **Interviewer instructions: If this is the enrollment visit, say “In the past 2 weeks” instead of “Since your last study visit”.**

1. Since your last study visit, have you had any of the following symptoms?

Fever	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Rash	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Red eyes lasting more than 2 hours	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Joint pain or swelling	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused

- ❖ **If the respondent answered YES to any of the symptoms above, go to question #2.**
- ❖ **If not, go to question #7.**

2. Since your last study visit, did you seek medical care for any or all of these symptoms at a health facility other than [study health facility name]?

- ₁ Yes → Go to question #2a
- ₀ No → Go to question #3
- ₇₇ Don't know → Go to question #3
- ₈₈ Refused → Go to question #3

2a. When did you seek care?	____ / ____ / ____ <input type="checkbox"/> ₇₇ Don't know D D M M M Y Y Y Y <input type="checkbox"/> ₈₈ Refused
2b. Where did you seek care?	Facility name: _____ Facility location: _____
2c. When you sought care for these symptoms, did a medical provider tell you that you might have any of the following?	
Zika virus	

Dengue	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Chikungunya	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Mayaro	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Yellow Fever	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Cytomegalovirus	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Rubella	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Toxoplasmosis	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Syphilis	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Chicken Pox	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Parvovirus	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Herpes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Other	<input type="checkbox"/> ₁ Yes: specify: _____			
	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused	

3. If participant said "Yes" to **fever** in question #1:

3a. When you had a fever, what was the highest temperature you had?	_____ degrees Celsius <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
3b. When did the fever start?	____/____/____/____/____/____/____/____ D D M M M Y Y Y Y <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused
3c. How many days did it last?	_____ days <input type="checkbox"/> ₆₆ Still ongoing <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused

4. If participant said "Yes" to **rash** in question #1:

4a. When you had the rash, was it itchy?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
4b. Was the rash bumpy?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
4c. On what part of your body did you see the rash first?				
Face	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Neck	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Chest	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Stomach	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Arms	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Hands	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Back	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Legs	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Feet	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Buttocks/genital area	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
4d. To which parts of the body did the rash spread?				
Face	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Neck	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Chest	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Stomach	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Arms	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Hands	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Back	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused

Legs	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Feet	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Buttocks/genital area	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused

4e. When did the rash start?	_____ / _____ / _____ D D M M M Y Y Y Y <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused			
4f. How many days did it last?	_____ days <input type="checkbox"/> ₆₆ Still ongoing <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused			

5. If participant said "Yes" to red eyes in question #1:

5a. When you had red eyes, were your eyes itchy?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
5b. Were both of your eyes red or just one?	<input type="checkbox"/> ₂ Both	<input type="checkbox"/> ₁ Only one	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
5c. Was there any discharge? (Fluid or pus coming from your eye)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
5d. When did you first notice your eyes were red?	_____ / _____ / _____ D D M M M Y Y Y Y <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused			
5e. How many days did it last?	_____ days <input type="checkbox"/> ₆₆ Still ongoing <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused			

6. If participant said "Yes" to joint swelling or pain in question #1:

6a. When your joints were swollen or painful, which joints were affected?				
Neck	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Shoulders	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Back	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Hips	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Knees	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Ankles	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Toes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Elbows	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Wrists	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Fingers	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
6b. When did you first notice your joints being swollen or painful?	_____ / _____ / _____ D D M M M Y Y Y Y <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused			
6c. How many days did it last?	_____ days <input type="checkbox"/> ₆₆ Still ongoing <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused			

7. Since your last study visit, did you have any of the following symptoms:

Nausea	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Vomiting	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Diarrhea	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Coughing	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Sneezing	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Runny nose	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Sore throat	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Swollen lymph nodes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Dizziness or fainting	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Numbness or tingling in your hands or feet	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Ringing in your ears	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Tiredness or fatigue	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Muscle weakness (lack of muscle strength)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Muscle aches (muscle pains)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Headache	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Back pain	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Abdominal pain	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Eye pain (e.g., burning, sharp, dull, gritty, throbbing, or aching of the eyes)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Sensitivity to light	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Pain behind the eyes (e.g., pressure behind the eyes)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Itchy skin without a rash	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Skin redness without a rash	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Chest pain	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Shortness of breath	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Blood in your urine	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Nosebleeds	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Black, tarry stools	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
Constipation	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
[Women only:] Vaginal bleeding	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
	<input type="checkbox"/> ₆₆ Not applicable			
[Women only:] Vaginal discharge	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
	<input type="checkbox"/> ₆₆ Not applicable			
[Men only:] Blood in your semen	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₇₇ Don't know	<input type="checkbox"/> ₈₈ Refused
	<input type="checkbox"/> ₆₆ Not applicable			

8. Since your last study visit, have you had any other unusual symptoms you would like to tell me about?

- ₁ Yes → What symptoms? _____
- ₀ No
- ₇₇ Don't know
- ₈₈ Refused

9. Since your last study visit, have you enrolled in another Zika Virus study?

- ₁ Yes → Which study? _____
- ₀ No
- ₇₇ Don't know

STUDY ID: _____ - ____ - _____

Refused

Thank you for completing this questionnaire. Please let me know if you have any questions.