

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

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

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

CDC estimates the average public reporting burden for this collection of information as 10 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- <sub>1</sub> Yes → What symptoms? \_\_\_\_\_
- <sub>0</sub> No
- <sub>77</sub> *Don't know*
- <sub>88</sub> *Refused*

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

- <sub>1</sub> Yes → Which study? \_\_\_\_\_
- <sub>0</sub> No
- <sub>77</sub> *Don't know*

STUDY ID: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

*Refused*

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