

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

Form Approved  
OMB No. 0920-1190  
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Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

D D M M M Y Y Y Y

Staff Administered: \_\_\_\_\_

### INFANT Symptoms Questionnaire

City: \_\_\_\_\_

Clinic: \_\_\_\_\_

❖ Interviewer instructions: If this is the first study visit, say “Since your baby was born” instead of “Since your baby’s first study visit”.

#### Let’s first update your baby’s insurance information.

1. What type of health insurance does your baby have?

- <sub>1</sub> Contributory    <sub>2</sub> Subsidized    <sub>3</sub> Not insured    <sub>4</sub> Specialized    <sub>5</sub> Exception
- <sub>6</sub> Indeterminate / independent    <sub>77</sub> Don't know    <sub>88</sub> Refused

2. What is the name of your baby’s health insurance provider?

Name: \_\_\_\_\_ <sub>77</sub> Don't know    <sub>88</sub> Refused

#### Now we have some questions about feeding your baby.

3. How are you currently feeding your baby?

Breast milk at the breast	<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
Breast milk from a bottle	<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
Infant formula from a bottle	<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
Solid foods	<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
Milk or other nutrition through a feeding tube or intravenously	<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

4. Have you noticed your baby having any difficulty related to feeding?

Excessive spitting up	<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
Excessive drooling	<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
Gagging/retching/coughing	<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
Difficulty swallowing	<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
Difficulty latching to the breast	<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 <input type="checkbox"/> <sub>99</sub> Not Applicable
Difficulty sucking at the breast or bottle	<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 <input type="checkbox"/> <sub>99</sub> Not Applicable
Arching back/squirming away	<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 <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused
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5. How many hours per day would you say your baby cries, on average:  
<sub>0</sub> <1 hour   
<sub>1</sub> 1-3 hours   
<sub>2</sub> 3-6 hours   
<sub>3</sub> 6-9 hours   
<sub>4</sub> 9-12 hours   
<sub>5</sub> >12 hours  
<sub>77</sub> Don't know   
<sub>88</sub> Refused

6. Since your baby's last study visit, did you seek medical care for your baby at a health facility other than [study health facility name]?

- <sub>1</sub> Yes           → Go to question #6a
- <sub>0</sub> No            → Go to question #7
- <sub>77</sub> Don't know → Go to question #7
- <sub>88</sub> Refused   → Go to question #7

6a. If YES, fill in the table below:	
Reason	Date of visit
Because your baby was sick (for example, a fever, rash, etc.)	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Tests	
Cranial ultrasound	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
MRI	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
CAT scan	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Hearing screening	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Vision screening	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Other: _____	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Providers	
Pediatrician	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Occupation/physical therapy	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Neurologist	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Gastroenterologist	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know <input type="checkbox"/> <sub>88</sub> Refused _____ / _____ / _____ 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
Other: _____	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) _____ / _____ / _____

	<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>	D D M M M   Y Y Y Y <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Hospitalization	<input type="checkbox"/> <sub>1</sub> Yes (Clinic name: _____) <i>Date of admission:</i> <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>	_____/_____/_____ D D M M M   Y Y Y Y <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
<b>6b. If YES, did a medical provider tell you that your baby might have any of the following?</b>		
Zika virus	<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>	
Dengue	<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>	
Chikungunya	<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>	
Mayaro	<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>	
Yellow Fever	<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>	
Cytomegalovirus	<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>	
Rubella	<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>	
Toxoplasmosis	<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>	
Syphilis	<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>	
Chicken Pox	<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>	
Parvovirus	<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>	
Herpes	<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>	
Other	<input type="checkbox"/> <sub>1</sub> Yes, specify: _____ <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>	

7. Since your baby's last study visit, has your baby 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> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Rash (not a diaper 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>
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> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
Joint pain (difficulty in moving)	<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>
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>
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>
Sleeping more than usual	<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>
Not feeding as much as usual	<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>
Blood in the 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>

- ❖ If the participant answered YES to **fever, rash, red eyes, or joint pain** go to question #8.
- ❖ If not, go to question #11.

8. If participant said "Yes" to **fever** in question # 7:

<b>8a.</b> When your baby had a fever, what was the highest temperature he/she had?	_____ degrees Celsius <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> <input type="checkbox"/> <sub>88</sub> <i>Refused</i>
<b>8b.</b> When did you first notice the fever?	____/____/____ <input type="checkbox"/> <sub>77</sub> <i>Don't know</i> D D M M M   Y Y Y Y <input type="checkbox"/> <sub>88</sub> <i>Refused</i>

<b>8c.</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

**9.** If participant said "Yes" to **rash** in question # 7:

<b>9a.</b> When your baby had a rash, did it seem 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>9b.</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>9c.</b> Where did you first see the rash?				
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>9d.</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>9d.</b> When did you first notice the rash?	_____ / _____ / _____ <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>9e.</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	

**10.** If participant said "Yes" to **red eyes** in question #7:

<b>10a.</b> Were both 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>10b.</b> Was there any discharge? (Fluid or pus coming from the 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>10c.</b> When did you first notice your baby's 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>10d.</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
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**11.** If participant said "Yes" to joint pain in question #7:

<b>11a.</b> When did you first notice the joint pain?	____/____/____ <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>11c.</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
<b>11d.</b> Where did you notice the joint pain?	
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
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
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

**12.** Since your baby's last study visit, did your baby have 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

**13.** Since your last study visit, have you or your baby enrolled in another Zika Virus study?

<sub>1</sub> Yes, I did → Which study? \_\_\_\_\_  
<sub>2</sub> Yes, my baby did → Which study? \_\_\_\_\_  
<sub>3</sub> Yes, my baby and I did → Which study? \_\_\_\_\_  
<sub>0</sub> No  
<sub>77</sub> Don't know  
<sub>88</sub> Refused

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