

STUDY ID: _____ - ____ - _____

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 | |

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| | | | | |
|-----------------|---|---|---|--|
| 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? | _____ / _____ / _____ <input type="checkbox"/> ₇₇ Don't know D D M M M Y Y Y Y <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? | _____ / _____ / _____ <input type="checkbox"/> ₇₇ Don't know D D M M M Y Y Y Y <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? | _____ / _____ / _____ <input type="checkbox"/> ₇₇ Don't know D D M M M Y Y Y Y <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.