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Site code	Participant code	Pregnant Woman	
II		II	
Today's date	::/// MM	-	

Form Approved OMB No. 0920-XXX Exp. Date XX/XX/20XX





ZIKV RNA Persistence (ZIRP): Pregnant Woman Symptom Questionnaire

TO BE COMPLETED BY PATIENT

Part I: Symptoms

We will now ask you some questions about symptoms you might have had or are currently experiencing.

1. In the past 2 weeks, did you have fever (>=100.4 F/38.0 C)? \Box_1 Yes \Box_0 No \Box_{77} Don't know \Box_{88} Refuse <u>If YES</u>:

1a.When did the fever start?

 $\frac{-1}{M} \frac{-1}{D} \frac{-1}{D} \frac{-1}{Y} \frac{-1}{Y} \frac{-1}{Y} \frac{-1}{Y} = \frac{-1}{2}$

1b. What was the highest temperature you had?

_____ degrees \Box_1 Celsius \Box_2 Fahrenheit \Box_{77} Don't know \Box_{88} Refuse

1c. How did you take your temperature?

 \Box_1 Thermometer \Box_2 Feeling your forehead \Box_3 Other \Box_{77} Don't know \Box_{88} Refuse

1c.a. If thermometer, how did you measure your temperature?

 \Box_1 Orally \Box_2 Rectally \Box_3 Under the arm \Box_4 In the ear \Box_{77} Don't know \Box_{88} Refuse

1d. How many days did it last?

_____ days \Box_{66} Still ongoing \Box_{77} Don't know \Box_{88} Refuse

1e. Did you take any medication for it? \Box_0 No \Box_1 Yes \Box_{77} Don't know \Box_{88} Refuse *If* yes,

Public reporting burden of this collection of information is estimated to average 8 minutes, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1189).

Site code Participant code Pregnant	
Woman II III I_0_I	
Today's date:// MMDDYYYY	
	□ ₁₁ Aspirin Dose mg/kg □ ₁₂ Ibuprofen Dose mg/kg
	□ ₁₃ Acetaminophen (tylenol) Dose mg/kg □ ₁₄ Other
2. In the past 2 weeks, did you have a rash? <u>If YES</u> :	\Box_1 Yes \Box_0 No \Box_{77} Don't know \Box_{88} Refuse
2a. On what date did the rash start?	
$\frac{1}{M} \frac{1}{M} \frac{1}{D} \frac{1}{D} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y}$	77 Don't know \square_{88} Refuse
2b. How many days did it last?	
days	ongoing D ₇₇ Don't know B ₈₈ Refuse
2c. When you had the rash, was it itchy	/?
\Box_1 Yes \Box_0 No \Box_{77} Don't kn	ow \square_{88} Refuse
2d. When you had the rash, what did it	look like?
\Box_0 Bumpy \Box_1 Blotchy \Box_2 O	ther □ ₇₇ Don't know □ ₈₈ Refuse
2e. Where was the rash? (Check all the	at apply)
$\Box_1 \operatorname{Face} \Box_2 \operatorname{Neck} \Box_3 \operatorname{Ches} \\ \Box_7 \operatorname{Back} \Box_8 \operatorname{Legs} \Box_9 \operatorname{Feet} \\ \end{array}$	St \square_4 Stomach \square_5 Arms \square_6 Hands \square_{10} All over my body \square_{77} Don't know \square_{88} Refuse
3. In the past 2 weeks, did you have red eyes \Box_1 Yes \Box_0 No \Box_{77} Don't know \Box_{88} Re	
3a. On what date did you first notice yo	our eyes were red?
	77 Don't know 🛛 88 Refuse

CDC Centers for Disease Control and Prevention

GOBIERNO DE PUERTO RICO Departamento de Salud

AD DE PILIPIO

		CONTROL Centers for Disease Control and Prevention
Site code	Participant code Pregnant	
I	Woman II_I I_I	GOBIERNO DE PUERTO RICO Departamento de Salud
Today's date:		
3b. H	low many days did it last?	
	days \Box_{66} Still ongoing \Box_{77} Don't know \Box_{88} Refuse	
3c. W	Vhen you had red eyes, were your eyes itchy?	
	\Box_1 Yes \Box_0 No \Box_{77} Don't know \Box_{88} Refuse	
3d. W	Vere both of your eyes red or just one?	
	\square_2 Both \square_1 Only one \square_{77} Don't know \square_{88} Refuse	
3e. W	Vas there any discharge? (Fluid or pus coming from your eye)	
	\Box_1 Yes \Box_0 No \Box_{77} Don't know \Box_{88} Refuse	
4. In the past <u>If YES</u> :	at 2 weeks, did you joint pain or swelling? \Box_1 Yes \Box_0 No \Box_{77} Don't know \Box	l ₈₈ Refuse
5a. O	On what date did you first notice your joints being swollen or painful?	
	$\frac{1}{M} \frac{1}{M} \frac{1}{D} \frac{1}{D} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} = \frac{1}{T}$	
5b. H	low many days did it last?	
	days \Box_{666} Still ongoing \Box_{777} Don't know \Box_{888} Refuse	
5c. W	Vhen your joints were swollen or painful, which joints were affected? (Check all tha	t apply)

 $\Box_0 \text{ Neck } \Box_1 \text{ Shoulders } \Box_2 \text{ Back } \Box_3 \text{ Hips } \Box_4 \text{ Knees } \Box_5 \text{ Ankles } \Box_6 \text{ Toes } \Box_7 \text{ Elbows } \Box_8 \text{ Wrists } \Box_9 \text{ Fingers } \Box_{77} \text{ Don't know } \Box_{88} \text{ Refuse } \Box_7 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_7 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_7 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_{88} \text{ Refuse } \Box_8 \text{ Don't know } \Box_8 \text{ Refuse } \Box_8 \text{ Don't know } \Box_8 \text{ Don$

5. In the past 2 weeks, did you have any of the following symptoms?

Black, tarry stools	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse
Blood in your urine	\Box_1 Yes	□₀ No	□77 Don't know	□ ₈₈ Refuse
Chest pain	\Box_1 Yes	□₀ No	□77 Don't know	□ ₈₈ Refuse
Constipation	\Box_1 Yes	□₀ No	□77 Don't know	□ ₈₈ Refuse
Coughing	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse

Site code	Participant code	Pregnant Woman
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Diamhaa				
Diarrhea		□ ₀ No	Don't know	□ ₈₈ Refuse
Dizziness or fainting	\Box_1 Yes	□₀ No	D ₇₇ Don't know	□ ₈₈ Refuse
Eye pain	\Box_1 Yes	□₀ No	□ ₇₇ Don't know	□ ₈₈ Refuse
Headache	\Box_1 Yes	□₀ No	□ ₇₇ Don't know	□ ₈₈ Refuse
Itchy skin without a rash	\Box_1 Yes	□₀ No	□ ₇₇ Don't know	□ ₈₈ Refuse
Muscle aches	\square_1 Yes	\square_0 No	\square_{77} Don't know	□ ₈₈ Refuse
Muscle weakness	□₁ Yes	□₀ No	□ ₇₇ Don't know	□ ₈₈ Refuse
Nausea	\square_1 Yes	\square_0 No	□ ₇₇ Don't know	□ ₈₈ Refuse
Nosebleeds	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse
Numbness or tingling in your hands or feet	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse
Ringing in your ears	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse
Runny nose	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse
Sensitivity to light	\Box_1 Yes	□₀ No	□77 Don't know	□ ₈₈ Refuse
Shortness of breath	\Box_1 Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse
Skin redness without a rash	\Box_1 Yes	□₀ No	□77 Don't know	□ ₈₈ Refuse
Sneezing	\Box_1 Yes	□₀ No	□77 Don't know	□ ₈₈ Refuse
Sore throat	\Box_1 Yes	\square_0 No	□ ₇₇ Don't know	□ ₈₈ Refuse
Swollen lymph nodes	□ ₁ Yes	\square_0 No	□ ₇₇ Don't know	□ ₈₈ Refuse
Tiredness or fatigue	□ ₁ Yes	\square_0 No	□ ₇₇ Don't know	□ ₈₈ Refuse
Vomiting	□ ₁ Yes	\square_0 No	□ ₇₇ Don't know	□ ₈₈ Refuse
Vaginal bleeding	□ ₁ Yes	\square_0 No	□ ₇₇ Don't know	□ ₈₈ Refuse
Vaginal discharge	□₁ Yes	\square_0 No	□77 Don't know	□ ₈₈ Refuse

6. In the past 2 weeks, have you had any other symptom from the ones mentioned above? \Box_1 Yes \Box_0 No \Box_{77} Don't know \Box_{88} Refuse

6a. If YES, which ones?

Symptom 1. _____ Symptom 2. _____ Symptom 3. _____ Symptom 4. Symptom 5. _____

	CODE Centers for Disease Control and Prevention
Site code Participant code Pregnant	
Woman	GOBIERNO DE PUERTO RICO Departamento de Salud
Today's date:// MMDDYYYY	
TO BE COMPLETED BY STUDY STAFF	
PART I: Microbiology testing	
7. Was a blood specimen taken? \Box_1 Yes \Box_0 No 7.1. If no, why no?	
7.2 If yes,	
7.2a. Date of specimen collection (mm/dd/yyyy):7.2b. Time of specimen collection (hh:mm):	
7.2c. Date specimen was sent to laboratory (mm/dd/yyyy):	
7.2d. Type of test:	
□₀ RT-PCR □₁.lgM	
□₂. RT-PCR & IgM □₃ Other	
8. Was a urine sample taken? \Box_1 Yes \Box_0 No 8.1 <i>If no,</i> why?	
8.2 If yes.	
8.2a. Date of specimen collection (mm/dd/yyyy): 8.2b. Time of specimen collection (hh:mm):	
8.2c. Date specimen was sent to laboratory (mm/dd/yyyy):	
8.2d. Type of test:	
□₀ RT-PCR □₁.IgM	
□₂.RT-PCR & IgM □₃ Other	
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