Att. C 3

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

Site code Participant code Pregnant Woman

I__I I___I___I___I I_I

Today's date: ____/_____/_____
MM DD YYYY

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)? ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Don't know ☐$_{88}$ Refuse
*If **YES** :*

1a.When did the fever start?

__ __/__ __ /__ __ __ __ ☐$_{77}$ Don't know ☐$_{88}$ Refuse
M M D D Y Y Y Y

1b. What was the highest temperature you had?

_____ degrees ☐$_1$ Celsius ☐$_2$ Fahrenheit ☐$_{77}$ Don't know ☐$_{88}$ Refuse

1c. How did you take your temperature?

☐$_1$ Thermometer ☐$_2$ Feeling your forehead ☐$_3$ Other ☐$_{77}$ Don't know ☐$_{88}$ Refuse

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

☐$_1$ Orally ☐$_2$ Rectally ☐$_3$ Under the arm ☐$_4$ In the ear ☐$_{77}$ Don't know ☐$_{88}$ Refuse

1d. How many days did it last?

_____ days ☐$_{66}$ Still ongoing ☐$_{77}$ Don't know ☐$_{88}$ Refuse

1e. Did you take any medication for it? ☐$_0$ No ☐$_1$ Yes ☐$_{77}$ Don't know ☐$_{88}$ Refuse
If yes,

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☐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? ☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse
*If **YES**:*

2a. On what date did the rash start?

__ __/__ __ /__ __ __ __ ☐77 Don't know ☐88 Refuse
M M D D Y Y Y Y

2b. How many days did it last?

_____ days ☐66 Still ongoing ☐77 Don't know ☐88 Refuse

2c. When you had the rash, was it itchy?

☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse

2d. When you had the rash, what did it look like?

☐0 Bumpy ☐1 Blotchy ☐2 Other ☐77 Don't know ☐88 Refuse

2e. Where was the rash? *(Check all that apply)*

☐1 Face ☐2 Neck ☐3 Chest ☐4 Stomach ☐5 Arms ☐6 Hands
☐7 Back ☐8 Legs ☐9 Feet ☐10 All over my body ☐77 Don't know ☐88 Refuse

3. In the past 2 weeks, did you have red eyes lasting more than a couple of hours?
☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse
*If **YES**:*

3a. On what date did you first notice your eyes were red?

__ __/__ __ /__ __ __ __ ☐77 Don't know ☐88 Refuse
M M D D Y Y Y Y

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3b. How many days did it last?

_____ days ☐66 Still ongoing ☐77 Don't know ☐88 Refuse

3c. When you had red eyes, were your eyes itchy?

☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse

3d. Were both of your eyes red or just one?

☐2 Both ☐1 Only one ☐77 Don't know ☐88 Refuse

3e. Was there any discharge? (Fluid or pus coming from your eye)

☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse

4. In the past 2 weeks, did you joint pain or swelling? ☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse
*If **YES** :*

5a. On what date did you first notice your joints being swollen or painful?

__ __/__ __ /__ __ __ __ ☐77 Don't know ☐88 Refuse
M M D D Y Y Y Y

5b. How many days did it last?

_____ days ☐666 Still ongoing ☐777 Don't know ☐888 Refuse

5c. When your joints were swollen or painful, which joints were affected? *(Check all that apply)*

☐0 Neck ☐1 Shoulders ☐2 Back ☐3 Hips ☐4 Knees ☐5 Ankles ☐6 Toes
☐7 Elbows ☐8 Wrists ☐9 Fingers ☐77 Don't know ☐88 Refuse

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

Black, tarry stools	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Blood in your urine	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Chest pain	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Constipation	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Coughing	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse

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Diarrhea	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Dizziness or fainting	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Eye pain	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Headache	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Itchy skin without a rash	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Muscle aches	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Muscle weakness	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Nausea	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Nosebleeds	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Numbness or tingling in your hands or feet	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Ringing in your ears	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Runny nose	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Sensitivity to light	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Shortness of breath	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Skin redness without a rash	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Sneezing	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Sore throat	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Swollen lymph nodes	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Tiredness or fatigue	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Vomiting	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Vaginal bleeding	☐1 Yes	☐0 No	☐77 Don't know	☐88 Refuse
Vaginal discharge	☐1 Yes	☐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?
☐1 Yes ☐0 No ☐77 Don't know ☐88 Refuse

*6a.**If YES**, which ones*?

Symptom 1. _____

Symptom 2. _____

Symptom 3. _____

Symptom 4. _____

Symptom 5. _____

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TO BE COMPLETED BY STUDY STAFF

PART I: Microbiology testing

7. Was a blood specimen taken? ☐1 Yes ☐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. IgM
   ☐2. RT-PCR & IgM
   ☐3 Other

8. Was a urine sample taken? ☐1 Yes ☐0 No
   8.1 *If no,* 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