**Day of follow-up: 0/14 (Date of specimen collection)**

**Date (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name (First Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Household ID: WI-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HH member ID: WI-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Household Member Symptom Diary**

1. Who is providing this information today?

 [ ]  Self [ ]  Parent/guardian

 [ ]  Other, specify name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the current time? \_\_\_\_\_\_\_\_\_\_\_\_ [ ]  AM [ ]  PM
2. Did you sleep in the household last night? [ ]  Yes [ ]  No
3. During the past 24 hours, have you experienced any of the following symptoms?

| **Symptom** | **Experienced in the past 24 hours?** |
| --- | --- |
| Documented Fever >=100.4F (38C)  Highest temp \_\_\_\_\_\_F | [ ] Yes [ ] No [ ] Unknown |
| Subjective fever (felt feverish) | [ ] Yes [ ] No [ ] Unknown |
| Chills | [ ] Yes [ ] No [ ] Unknown |
| Fatigue (tired) | [ ] Yes [ ] No [ ] Unknown |
| Headache | [ ] Yes [ ] No [ ] Unknown |
| Muscle aches | [ ] Yes [ ] No [ ] Unknown |
| Runny nose | [ ] Yes [ ] No [ ] Unknown |
| Sore throat | [ ] Yes [ ] No [ ] Unknown |
| Cough (new onset or worsening of chronic cough)[ ]  Dry [ ]  Productive | [ ] Yes [ ] No [ ] Unknown |
| Discomfort/burning while breathing | [ ] Yes [ ] No [ ] Unknown |
| Shortness of breath | [ ] Yes [ ] No [ ] Unknown |
| Wheezing  | [ ] Yes [ ] No [ ] Unknown |
| Chest Pain | [ ] Yes [ ] No [ ] Unknown |
| Nausea/Vomiting | [ ] Yes [ ] No [ ] Unknown |
| Loss of taste[ ]  Complete [ ]  Partial  | [ ] Yes [ ] No [ ] Unknown |
| Loss of smell[ ]  Complete [ ]  Partial  | [ ] Yes [ ] No [ ] Unknown |
| Abdominal pain | [ ] Yes [ ] No [ ] Unknown |
| Diarrhea (≥3 loose/looser than normal stools/24hr period) | [ ] Yes [ ] No [ ] Unknown |
| Other, specify:  | [ ] Yes [ ] No [ ] Unknown |

Who should we contact for your daily reminder? [ ]  Me [ ]  Other family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact: [ ]  Phone call [ ]  Text [ ]  Email

Phone/email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_