

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: \_\_\_\_\_

2. What is the current time? \_\_\_\_\_  AM     PM

3. Did you sleep in the household last night?     Yes     No

4. During the past 24 hours, have you experienced any of the following symptoms?

Symptom	Experienced in the past 24 hours?
Documented Fever $\geq 100.4^{\circ}\text{F}$ ( $38^{\circ}\text{C}$ ) Highest temp _____ F	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fatigue (tired)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cough (new onset or worsening of chronic cough) <input type="checkbox"/> Dry <input type="checkbox"/> Productive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Discomfort/burning while breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Loss of taste <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Loss of smell <input type="checkbox"/> Complete <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Diarrhea ( $\geq 3$ loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

Preferred method of contact:  Phone call  Text  Email

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