Symptom and Care Survey

Adding new Part 3 ID **1**

Event Name: **Visit #1**

Part 3 ID	1
Part 2 ID * must provide value	
Research assistant * must provide value	○ Andy reset
Visit date * must provide value	Today M-D-Y Format: MM/DD/YYYY
Note for study staff: If this is the participant's first Part 3 visit (Visit #1) the previous visit date should be the participant's Part 2 visit date.	
Previous visit date * must provide value	Today M-D-Y Format: MM/DD/YYYY
Visit number * must provide value	Format: N or NN

Visit number * must provide value	1 Format: N or NN

Form Approved
OMB No. 0920-New
Expiration Date: XX/XX/XXXX
Public reporting burden of this collection of information is estimated to average 5 minutes per response, 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: OMB-PRA (0920-New).

We've already discussed the following question with you but would like to document your answer electronically. If you have any questions about what we're asking, please talk to the study staff before responding.

Do you agree to take part in the study? * must provide value	○ Yes ○ No reset

We are asking you to agree to freeze part of your blood and oral fluid specimens at the CDC for future use. We may use these samples for research in the future. Nothing that could be linked to you will be kept with your blood or oral fluid specimens. We are not sure what studies might be done in the future. They might include standard tests as done at hospitals, tests for HIV or other viruses or on your immune system (ability to fight infection). We will not test for genetic problems or use the blood or oral fluid specimens for cloning or commercial purposes.

Do you agree to storage of your specimens for future use? * must provide value	○ Yes, I give consent for my blood and oral fluid specimens to be stored at CDC for the future use as outlined above. ○ No, I DO NOT give consent for my blood and oral fluid specimens to be stored at CDC for future research. reset

Have you previously participated in an HIV vaccine trial?

* must provide value

- ○ Yes
- ○ No
- ○ Don't know

reset

Which did you receive as part of your study participation?

* must provide value

- ○ A vaccine
- ○ A placebo
- ○ Don't know/I never learned which one I received

reset

Since your last visit on _____, have you had any of these symptoms? Check all that apply.

* must provide value

- ☑ Sore throat
- ☑ Fever and/or chills
- ☑ Nausea
- ☑ Vomiting
- ☑ Diarrhea
- ☑ Headache(s)
- ☑ Fatigue
- ☑ Soreness or pain in your joints or muscles
- ☑ Swollen or sore lymph nodes
- ☑ Body rash
- ☑ Sores, bumps, or rashes on your genitals
- ☑ Changes in hearing or vision
- ☑ Rash on the palms of your hands or the soles of your feet
- ☑ Abdominal pain
- ☑ I haven't experienced any of these symptoms in the last 3 months
- ☐ Refuse to answer

You said that you have had a sore throat since your last visit on _____. Do you have a sore throat today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience a sore throat?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience a sore throat?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have had a fever and/or chills since your last visit on _____. Do you have a fever and/or chills today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience a fever and/or chills?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience a fever and/or chills?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have had nausea since your last visit on _____. Do you have nausea today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience nausea?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience nausea?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have experienced vomiting since your last visit on _____. Did you vomit today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience vomiting?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience vomiting?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have experienced diarrhea since your last visit on _____. Did you have diarrhea today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience diarrhea?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience diarrhea?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have experienced a headache since your last visit on _____. Do you have a headache today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience a headache?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience a headache?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

You said that you have experienced fatigue since your last visit on _____. Do you have fatigue today?

○ Yes
◉ No

reset

* must provide value

When did you first experience fatigue?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

When did you last experience fatigue?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

You said that you have experienced soreness or pain in your muscles or joints since your last visit on _____. Do you have soreness or pain in your muscles or joints today?

○ Yes
◉ No

reset

* must provide value

When did you first experience soreness or pain in your muscles or joints?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

When did you last experience soreness or pain in your muscles or joints?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

You said that you have experienced swollen or sore lymph nodes since your last visit on _____. Do you have swollen or sore lymph nodes today?

- ○ Yes
- ◉ No

reset

* must provide value

When did you first experience swollen or sore lymph nodes?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

When did you last experience swollen or sore lymph nodes?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

You said that you have experienced a body rash since your last visit on _____. Do you have a body rash today?

- ○ Yes
- ◉ No

reset

* must provide value

When did you first experience a body rash?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

When did you last experience a body rash?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have experienced sores, bumps, or rashes on your genitals since your last visit on _____. Do you have sores, bumps, or rashes on your genitals today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience sores, bumps, or rashes on your genitals?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience sores, bumps, or rashes on your genitals?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

You said that you have experienced changes in your hearing or vision since your last visit on _____. Do you have changes in your hearing or vision today?

* must provide value

- ○ Yes
- ◉ No

reset

When did you first experience changes in your hearing or vision?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you last experience changes in your hearing or vision?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

You said that you have experienced rashes on the palms of your hands or on the soles of your feet since your last visit on _____. Do you have rashes on the palms of your hands or on the soles of your feet today?

- ○ Yes
- ◉ No

reset

* must provide value

When did you first experience rashes on the palms of your hands or on the soles of your feet?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

When did you last experience a rash on the palms of your hands or on the soles of your feet?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

You said that you have experienced abdominal pain since your last visit on _____. Do you have abdominal pain today?

- ○ Yes
- ◉ No

reset

* must provide value

When did you first experience abdominal pain?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

When did you last experience abdominal pain?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the exact day, please just enter the month and the year (MM/YYYY).

Format: MM/DD/YYYY

* must provide value

Did you go to a doctor or health care provider because of your symptom(s)?

- ○ Yes
- ○ No

reset

* must provide value

Did you miss work or school because of your symptom(s)?

- ○ Yes
- ○ No
- ○ Don't know

reset

* must provide value

Were you hospitalized because of your symptom(s)?

- ○ Yes
- ○ No

reset

* must provide value

Do you currently have a doctor or medical provider for HIV care?

* must provide value

○ Yes
○ No

reset

Since your last visit on _____, have you been to a doctor or medical provider for HIV care?

* must provide value

◉ Yes
○ No

reset

When did you last see your HIV doctor or medical provider?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the day, please just enter the month and year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

Are you currently taking medicines to treat your HIV?

* must provide value

○ Yes
◉ No

reset

Have you taken medicines to treat your HIV since your last visit on _____?

* must provide value

◉ Yes
○ No

reset

When did you start taking medicines to treat your HIV?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the day, please just enter the month and year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

When did you stop taking medicines to treat your HIV?

Please enter a day, month, and year in MM/DD/YYYY format. If you cannot remember the day, please just enter the month and year (MM/YYYY).

* must provide value

Format: MM/DD/YYYY

This is the end of the survey. Please save and exit.

Form Status

Complete?

Incomplete

Save & Exit Form | Save & ...

-- Cancel --