

Appendix E – Symptom Diary

Evaluating the Association between Serum Concentrations of Per- and Polyfluoroalkyl Substances (PFAS) and Symptoms and Diagnoses of Selected Acute Viral Illnesses Symptom Diary

ATSDR estimates the average public reporting burden for this collection of information as 1 hour per quarter (or 4 hours per year), including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0923-xxxx).

Name: _____

Date when last survey was completed: (month/day/year)

Instructions: The purpose of this chart is to help you keep track of any symptoms, travel prior to symptom onset, medical care or testing you may receive, and any close contact with people with COVID-19 during the time between questionnaires. Please use this chart to record any symptom you experience and how many consecutive days (days in a row) that symptom lasted. This chart is for your own use and does not need to be submitted with your questionnaires. You are receiving multiple charts with this packet, please save them and use them for the duration of the study. Additionally, we will send you a new symptom diary with each follow-up study to help you remember to use them. If you need more space for additional episodes of illness, please make a copy of this chart. If you and your child(ren) are both participating in this study, keep a separate diary for each participant.

If you would like an electronic version of these symptom diaries, please contact CDC/ATSDR at **XXX-XXX-XXXX** or pfasviralstudy@cdc.gov.

An **Episode** of illness is one distinct period of time when you were sick or experienced a set of symptoms. An **Episode** of illness would start when you first started to feel sick and would end when you felt back to normal, even if the specific symptoms changed during that time (for example, an illness might start with a sore throat and end with a cough). In Tables 2, 3, and 4, **Episode #1** refers to the same period of time in which you experienced symptoms for Episode #1 in Table 1. The same applies for each Episode. For example, **Episode #1** may represent an illness in January and **Episode #2** may represent a different illness in March.

Table 1. Symptoms

| Symptom | Episode 1 | | Episode 2 | | Episode 3 | | Episode 4 | | Episode 5 | |
|---|---------------|------------------------|---------------|------------------------|---------------|------------------------|---------------|------------------------|---------------|------------------------|
| | Date of onset | # of days with symptom | Date of onset | # of days with symptom | Date of onset | # of days with symptom | Date of onset | # of days with symptom | Date of onset | # of days with symptom |
| Fever (100 degrees or higher) | | | | | | | | | | |
| Felt feverish or warm (did not take temperature with a thermometer) | | | | | | | | | | |
| Chills or repeated shaking with chills | | | | | | | | | | |
| Cough | | | | | | | | | | |
| Shortness of breath or difficulty breathing | | | | | | | | | | |
| Nasal congestion (stiffness) | | | | | | | | | | |
| Runny nose | | | | | | | | | | |
| Sore throat | | | | | | | | | | |
| New Loss of taste or smell | | | | | | | | | | |
| Headache | | | | | | | | | | |
| Fatigue | | | | | | | | | | |
| Muscle pains or body aches | | | | | | | | | | |
| Nausea or stomach upset | | | | | | | | | | |
| Vomiting | | | | | | | | | | |
| Diarrhea | | | | | | | | | | |
| Unexplained rash | | | | | | | | | | |

Table 2. Travel prior to illness

Did you/your child travel using the following modes of transportation in the 14 days before onset of symptoms? Please don't include local daily travel for work, school, or routine activities such as grocery shopping.

| Travel by: | Episode 1 | | Episode 2 | | Episode 3 | | Episode 4 | | Episode 5 | |
|------------|-----------|----|-----------|----|-----------|----|-----------|----|-----------|----|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| | | | | | | | | | | |

| | Episode 1 | | Episode 2 | | Episode 3 | | Episode 4 | | Episode 5 | |
|----------|-----------|--|-----------|--|-----------|--|-----------|--|-----------|--|
| Bus | | | | | | | | | | |
| Train | | | | | | | | | | |
| Airplane | | | | | | | | | | |

Table 3. Medical Care

| | Episode 1 | | Episode 2 | | Episode 3 | | Episode 4 | | Episode 5 | |
|--|-----------|----|-----------|----|-----------|----|-----------|----|-----------|----|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| Did you seek medical care for your symptoms? | | | | | | | | | | |
| Did you receive care at a Physician's Office (in person)? | | | | | | | | | | |
| Did you receive care from a Physician's office using Telehealth (by phone or computer)? | | | | | | | | | | |
| Did you receive care at an Urgent Care Clinic? | | | | | | | | | | |
| Did you receive care at a Hospital Emergency Department (ER)? | | | | | | | | | | |
| Were you hospitalized overnight for your symptoms? (not ER)? | | | | | | | | | | |
| Did you receive care at a Pharmacy (testing or treatment by a pharmacist or at a clinic located at/within a pharmacy)? | | | | | | | | | | |
| Did you receive a diagnosis from a physician? | | | | | | | | | | |
| If yes, what was the diagnosis | | | | | | | | | | |

Table 4. Diagnostic Testing

If you sought medical care for your symptoms, were any of the following tests performed? And what were the results? (+) indicates a positive test and (-) indicates a negative test. For the chest x-ray, (+) result means an abnormal result and (-) means a normal result.

| Type of test | Episode 1 | | | | Episode 2 | | | | Episode 3 | | | | Episode 4 | | | | Episode 5 | | | |
|--------------|-----------|-----|-----|-------|-----------|-----|-----|-------|-----------|-----|-----|-------|-----------|-----|-----|-------|-----------|-----|-----|-------|
| | Not | (+) | (-) | Don't | Not | (+) | (-) | Don't | Not | (+) | (-) | Don't | Not | (+) | (-) | Don't | Not | (+) | (-) | Don't |
| | | | | | | | | | | | | | | | | | | | | |

Protocol, PFAS/viral infection, v1.0

Last Revised: August 23, 2021

| | done | | know | done | | know | done | | know | done | | know | done | | know |
|--|------|--|------|------|--|------|------|--|------|------|--|------|------|--|------|
| Influenza (flu) nasal swab test | | | | | | | | | | | | | | | |
| RSV nasal swab test | | | | | | | | | | | | | | | |
| Nasal swab for other viruses (not including COVID-19) | | | | | | | | | | | | | | | |
| Strep test (throat swab) | | | | | | | | | | | | | | | |
| Chest x-ray | | | | | | | | | | | | | | | |
| COVID-19 diagnostic test: nasal swab, nasopharyngeal swab, mouth or throat swab, saliva test | | | | | | | | | | | | | | | |
| COVID-19 blood test (serology or antibody test) | | | | | | | | | | | | | | | |

Table 5 below provides a calendar option for tracking symptoms. You will need to fill in the month you are referring to at the top. There are 3 blank months included with this symptom diary. Please make additional copies if needed. Additionally, you can contact CDC/ATSDR at XXX-XXX-XXXX or pfasviralstudy@cdc.gov if you need additional copies sent to you.

Table 5. Symptom Calendar Tracking

| | Month/Year: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Fever (100 degrees or higher) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chills or repeated shaking with chills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cough | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shortness of breath or difficulty breathing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nasal congestion (stuffiness) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Runny nose | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sore throat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| New Loss of taste or smell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headache | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fatigue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Muscle pains or body aches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea or stomach upset | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abdominal pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vomiting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diarrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | Month/Year: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | |
| Fever (100 degrees or higher) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chills or repeated shaking with chills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cough | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shortness of breath or difficulty breathing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nasal congestion (stiffness) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Runny nose | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sore throat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| New Loss of taste or smell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headache | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fatigue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Muscle pains or body aches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea or stomach upset | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abdominal pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vomiting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diarrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | Month/Year: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | |
| Fever (100 degrees or higher) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chills or repeated shaking with chills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cough | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | Month/Year: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Shortness of breath or difficulty breathing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nasal congestion (stiffness) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Runny nose | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sore throat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| New Loss of taste or smell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headache | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fatigue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Muscle pains or body aches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea or stomach upset | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abdominal pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vomiting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diarrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Date of influenza vaccine (flu shot), if applicable: _____

Date(s) of COVID-19 vaccine:

| | Date (month/year) | Brand |
|----------------------|-------------------|---|
| 1 st dose | ___/____ | <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson <input type="checkbox"/> Other |
| 2 nd dose | ___/____ | <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson <input type="checkbox"/> Other |
| 3 rd dose | ___/____ | <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson <input type="checkbox"/> Other |

Questions specific to COVID-19

The items listed below could have happened more than once. If you answer yes to any of the following questions in this table, please enter the approximate date(s) that the item occurred. Keeping track of dates here will help you complete your follow up surveys. Use the date columns to list the approximate date or dates, starting with the earliest occurrence. If the event occurred more than five times, please list the remaining dates together in the last column.

For the questions below that ask about “COVID-19” testing, please note:

There are different types of COVID-19 tests available, those that can test for current infection or test for past infection.

- A **viral test** tells you if you have a current infection. Two types of viral tests can be used: nucleic acid amplification tests (often called PCR tests) and antigen tests. The viral test involves collecting a specimen with a nasal swab, nasopharyngeal swab, mouth or throat swab, or saliva test.

- An **antibody test** (also known as a serology test) is a blood test that might tell you if you had a past infection. Antibody tests are not used to diagnose a current infection.

| | NO | YES | | 1st approx. date (month/year) | 2nd approx. date (month/year) | 3rd approx. date (month/year) | 4th approx. date (month/year) | 5th approx. date (month/year) |
|---|----|-----|--|----------------------------------|-------------------------------------|----------------------------------|----------------------------------|----------------------------------|
| Were you in close contact (defined as within 6 ft for 15 minutes or more) with a person who you know has/had a positive viral test for COVID-19? | | | | | | | | |
| Were you in close contact (defined as within 6 ft for 15 minutes or more) with a person who you suspected has/had a positive viral test for COVID-19? | | | | | | | | |
| Have you been advised to self-quarantine (<u>separate yourself from others and monitor for signs of infection for 10-14 days</u>) because of exposure to someone with a positive COVID-19 viral test? | | | | | | | | |
| Have you provided care for someone who had a positive viral test for COVID-19 at the time you were providing care? | | | | | | | | |
| Have you had a positive viral test for COVID-19 while having no symptoms? | | | | | | | | |
| Have you had an antibody test for COVID-19 (either positive or negative)? | | | | | | | | |
| Have you had an antibody test for COVID-19 that was positive (indicated that you had antibodies to COVID-19)? | | | | | | | | |
| Besides you, has anyone else in your household had an illness that you suspected was COVID-19 but for which they did not receive testing for COVID-19? | | | | | | | | |
| Besides you, has anyone else in your household been tested with a viral test for COVID-19? | | | | | | | | |
| Besides you, has anyone else in your household had a positive viral test for COVID-19 while having no symptoms? | | | | | | | | |
| Besides you, has anyone else in your household had a positive viral test for COVID-19 while having symptoms? | | | | | | | | |