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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

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

	Episode 1		Episode 2		Episode 3		Episode 4		Episode 5	
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**	**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 (stuffiness)										
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.

	Episode 1		Episode 2		Episode 3		Episode 4		Episode 5	
Travel by:	**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.

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

	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)																															
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	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
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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
1st dose	__ __ /__ __ __ __	☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other
2nd dose	__ __ /__ __ __ __	☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other
3rd dose	__ __ /__ __ __ __	☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ 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 (separate yourself from others and monitor for signs of infection for 10-14 days) 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?								