# ATTACHMENT 4. FOLLOW-UP CLINICAL SURVEY

Today’s Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Interviewer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Investigation ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interview number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1**)** Since our last interview,did you experience any ongoing symptoms or a relapse in symptoms?

o Yes, relapse o Yes, ongoing o No ***(if no, skip to 2 if applicable)*** o Unknown/Not sure

1a) If relapse, how many reoccurrences have you had before this one? (*use chart to determine and verify which reoccurrence this might be*)

o 1 o 2 o 3 o 4 o 5

1b) If relapse, if you can remember, what dates did your previous symptoms go away and then come back (if possible):

Remittance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relapse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1c) If relapse, how would you describe the severity of the symptom relapse compared to your initial illness?

o More severe o Similar severity o Less severe o Unknown/Not sure

1d) If ongoing, did the symptoms go away? o Yes o No o Unknown/Not sure

 1d.1) If yes, what date? (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1e) If yes, please describe any symptoms that recurred or continued:

|  |  |  |
| --- | --- | --- |
| Fevero Yes o No o UnknownHighest temp: \_\_\_\_\_\_\_\_\_\_°Fo Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Chillso Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Headacheo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Fatigue/malaiseo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Muscle aches (myalgia)o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Joint pain (arthralgia)o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Back painYes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Red eyes (conjunctival injection)o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Retroorbital or eye paino Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Light sensitivity (photophobia)o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Muscle weaknesso Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Seizureso Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Stiff neck or neck paino Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Confusiono Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Tremors/Shakingo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Numbness or tinglingo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Loss of appetite o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Nauseao Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Vomitingo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Diarrheao Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Abdominal paino Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Sore throato Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Cougho Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Shortness of breatho Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Chest paino Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Painful urination (dysuria)o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Urinary incontinenceo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Difficulty emptying bladder (retention)o Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Painful ejaculationo Yes o No o Unknown o Not applicableo Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Scrotal and/or testicular pain (epididymitis, orchitis)o Yes o No o Unknown o Not applicableo Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Vaginal discharge (if applicable)o Yes o No o Unknown o Not applicableIf yes, please describe:o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Penile discharge (if applicable)o Yes o No o Unknown o Not applicableIf yes, please describe:o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Dizziness, lightheadedness, or vertigoo Yes o No o UnknownIf yes, please describe: o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom | Paralysiso Yes o No o UnknownIf yes, please describe:o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Rash o Yes o No o UnknownIf yes, please describe:o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom 5 | Excessive sweatingo Yes o No o Unknowno Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Hemorrhage (bleeding) [*List out all options below*]o Yes o No o UnknownIf yes, then specify: o Nose bleeds o Bleeding gums o Blood in stool o Heavy or abnormal menstruation o Tiny spots of bleeding under the skin or mucous membranes (petechiae)o Blood in urine (hematuria) o Blood in semen (hematospermia)o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |
| Other, please describe:o Recurrence, #: \_\_\_\_\_\_ ORo Ongoing symptom |

1e) If yes, did you seek healthcare when these symptoms recurred?

o Yes o No o Unknown

 1e.1) If yes, where did you seek care? Please provide dates if possible.

 o Emergency department o Primary care doctor o Urgent care

o Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If the participant is male and participating in the sample collection investigation:*

2. In the past 7 days, how many times did you ejaculate (not including ejaculation to collect a sample for this investigation)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If the patient has not experienced symptoms for 4 weeks, inform them that they have reached the endpoint of this part of the investigation and thank them for their participation. If the participant reported a relapse in symptoms, schedule a time to repeat the interview and thank them for their participation.***