

## 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?

Yes, relapse     Yes, ongoing     No **(if no, skip to 2 if applicable)**     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)

1     2     3     4     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?

More severe     Similar severity     Less severe     Unknown/Not sure

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

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

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

Fever <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Highest temp: _____°F <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Chills <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Headache <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Fatigue/malaise <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Muscle aches (myalgia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Joint pain (arthralgia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom

CDC estimates the average public reporting burden for this collection of information as 15 minutes per response, 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 CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

<p>Back pain</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Red eyes (conjunctival injection)</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Retroorbital or eye pain</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Light sensitivity (photophobia)</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Muscle weakness</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Seizures</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Stiff neck or neck pain</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Confusion</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Tremors/Shaking</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Numbness or tingling</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Loss of appetite</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Nausea</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Vomiting</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Diarrhea</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Abdominal pain</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Sore throat</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Cough</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Shortness of breath</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Chest pain</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Painful urination (dysuria)</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>	<p>Urinary incontinence</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p> <p><input type="radio"/> Recurrence, #: _____ OR</p> <p><input type="radio"/> Ongoing symptom</p>
<p>Difficulty emptying bladder (retention)</p>	<p>Painful ejaculation</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unknown</p>	<p>Scrotal and/or testicular pain (epididymitis, orchitis)</p>

<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Not applicable  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Not applicable  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Vaginal discharge (if applicable) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable If yes, please describe:  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		Penile discharge (if applicable) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable If yes, please describe:  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Dizziness, lightheadedness, or vertigo <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		Paralysis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Rash <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom 5		Excessive sweating <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Hemorrhage (bleeding) [ <i>List out all options below</i> ] <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, then specify: <input type="radio"/> Nose bleeds <input type="radio"/> Bleeding gums <input type="radio"/> Blood in stool <input type="radio"/> Heavy or abnormal menstruation <input type="radio"/> Tiny spots of bleeding under the skin or mucous membranes (petechiae) <input type="radio"/> Blood in urine (hematuria) <input type="radio"/> Blood in semen (hematospermia)  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		
Other, please describe:  <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom		

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

Yes    No    Unknown

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

Emergency department     Primary care doctor     Urgent care

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.***