Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/XXXX

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:

Fever o Yes o No o Unknown Highest temp: _____°F o Recurrence, #: _____ OR o Ongoing symptom	Chills o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Headache o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom
Fatigue/malaise o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Muscle aches (myalgia) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Joint pain (arthralgia) o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom

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

o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom	Not applicable o Recurrence, #: _____ OR o Ongoing symptom	o Yes o No o Unknown o Not applicable o Recurrence, #: _____ OR o Ongoing symptom

Vaginal discharge (if applicable) o Yes o No o Unknown o Not applicable If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom	Penile discharge (if applicable) o Yes o No o Unknown o Not applicable If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom
Dizziness, lightheadedness, or vertigo o Yes o No o Unknown If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom	Paralysis o Yes o No o Unknown If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom
Rash o Yes o No o Unknown If yes, please describe: o Recurrence, #: _____ OR o Ongoing symptom 5	Excessive sweating o Yes o No o Unknown o Recurrence, #: _____ OR o Ongoing symptom

Hemorrhage (bleeding) [*List out all options below*] o Yes o No o Unknown If 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, #: _____ OR o Ongoing symptom
Other, please describe: o Recurrence, #: _____ OR o 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.