

ATTACHMENT 3. INITIAL CLINICAL AND SOCIAL SURVEY

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Today's Date: ____/____/____ Interviewer Name: _____

Investigation ID: _____

County of residence: _____ State of residence: _____

What is your sex?

☐ Female ☐ Male

What is your race and/or ethnicity? Select all that apply and enter additional details in the spaces below.

☐ American Indian or Alaska Native – Provide details below. Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

☐ Asian – Provide details below.

☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Vietnamese
☐ Korean ☐ Japanese

If needed: enter, for example, Pakistani, Hmong, Afghan, etc

☐ Black or African American – Provide details below.

☐ African American ☐ Jamaican ☐ Haitian ☐ Nigerian
☐ Ethiopian ☐ Somali

If needed: enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc

☐ Hispanic or Latino – Provide details below.

☐ Mexican ☐ Puerto Rican ☐ Salvadoran ☐ Cuban
☐ Dominican ☐ Guatemalan

If needed: enter, for example, Colombian, Honduran, Spaniard, etc

☐ Middle Eastern or North African – Provide details below.

☐ Lebanese ☐ Iranian ☐ Egyptian ☐ Syrian

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☐ Iraqi ☐ Israeli

If needed: enter, for example, Moroccan, Yemeni, Kurdish, etc

☐ Native Hawaiian or Pacific Islander – *Provide details below.*

☐ Native Hawaiian ☐ Samoan ☐ Chamorro ☐ Tongan

☐ Fijian ☐ Marshallese

If needed: enter, for example, Chuukese, Palauan, Tahitian, etc

☐ White – *Provide details below.*

☐ English ☐ German ☐ Irish ☐ Italian

☐ Polish ☐ Scottish

If needed: enter, for example, French, Swedish, Norwegian, etc

We are going to ask you questions about the illness you had this year, for which you tested positive for Oropouche.

1) What date did your initial symptoms with this illness begin? (mm/dd/yyyy)

____/____/____

2) Were you hospitalized during your initial illness? ☐ Yes ☐ No ☐ Prefer not to answer

2a) If yes, for how many days? _____ days (dates of hospitalization if possible)

4a.1) Date of admission (mm/dd/yyyy): _____

☐ Unknown

4a.2) Date of discharge (mm/dd/yyyy): _____

☐ Unknown

2b) If yes, did you spend time in the intensive care unit (ICU)?

☐ Yes ☐ No ☐ Prefer not to answer

3) During your initial illness – when you first got sick, what were your symptoms?

Fever <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Highest temp: _____°F	Chills <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Headache <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Fatigue <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Malaise <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Muscle aches (myalgia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Joint pain (arthralgia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

Back pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Red eyes (conjunctival injection) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Retroorbital or eye pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Light sensitivity (photophobia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Muscle weakness <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Seizures <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Stiff neck or neck pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Confusion <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Tremors/Shaking <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Numbness or tingling <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Loss of appetite <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Nausea <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Vomiting <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Diarrhea <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Abdominal pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Sore throat <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Cough <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Shortness of breath <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Chest pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Painful urination (dysuria) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Urinary incontinence <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Difficulty emptying bladder (retention) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Painful ejaculation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable	Scrotal and/or testicular pain (epididymitis, orchitis) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable
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:	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:	
Dizziness, lightheadedness, or vertigo <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:	Paralysis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:	
Rash <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please describe:	Excessive sweating <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Hemorrhage (bleeding) [List out all options below] <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)
Other: _____	

4) Was there any point in your illness where your symptoms improved but then came back later?

☐ Yes ☐ No ☐ Unknown/Not sure

4a) If yes, how many times did this occur? _____ times

(IF 1, go to 4b)

(IF >1, go to 4b.1)

4b) If once, if you can remember, what dates did your symptoms go away and then come back:

Remittance: _____ Relapse: _____

4b.1) If the patient has had multiple relapses, use table below:

Recurrence number	Remittance Date (improved)	Relapse date (worsened or recurred)
1		
2		
3		
4		
5		

4c) If yes, how would you describe the severity of the symptom relapse compared to your initial illness?

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

4d) If yes, please describe any relapsing symptoms that occurred, and whether this symptom reoccurred or was ongoing

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	<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	
Back pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Red eyes (conjunctival injection) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Retroorbital or eye pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Light sensitivity (photophobia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Muscle weakness <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Seizures <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Stiff neck or neck pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Confusion <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Tremors/Shaking <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Numbness or tingling <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Loss of appetite <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Nausea <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Vomiting <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Diarrhea <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Abdominal pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

<input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	<input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	<input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Sore throat <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Cough <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Shortness of breath <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Chest pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Painful urination (dysuria) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Urinary incontinence <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom
Difficulty emptying bladder (retention) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Painful ejaculation <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	Scrotal and/or testicular pain (epididymitis, orchitis) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> 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	Excessive sweating	

If yes, please describe: <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom 5	<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	

4e) If yes, did you seek healthcare when these symptoms recurred?

☐ Yes ☐ No ☐ Prefer not to answer

4e.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: _____

Next, we have some questions about your medical history.

5) Do you have any underlying medical conditions?

☐ Yes ☐ No ☐ Don't know/Not sure ☐ Prefer not to answer

If yes, check any of the following conditions that apply.

☐ Asplenia (no spleen)

☐ Autoimmune disease (e.g., lupus, rheumatoid arthritis):

Describe _____

Medication(s): _____

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☐ Blood problems (e.g., sickle cell disease):

Describe _____

☐ Diabetes mellitus: ☐ Type I ☐ Type II

☐ Cancer: Describe _____

Medication(s): _____

☐ Cardiovascular (heart or blood vessel) disease ☐ Hypertension (high blood pressure)

☐ Chronic hepatitis or liver disease

☐ Chronic lung disease

☐ Immunosuppressive condition (any medical conditions that limit your ability to fight infections):

Describe _____

Medication(s): _____

☐ Renal (kidney) disease ☐ On dialysis

☐ Other _____

6) Do you take any medications that suppress your immune system?

☐ Yes

☐ No

☐ Unknown

7) In the 2 months before your illness, did you receive a blood transfusion or organ or tissue transplant?

☐ Yes

☐ No

☐ Unknown

7a) If yes, what did you receive (please provide dates)?

☐ Both

☐ Blood transfusion only

☐ Organ donation only

☐ Unsure

Dates: _____

8) (if applicable) Are you currently pregnant or were you at any point during your illness?

☐ Yes

☐ No

☐ Unknown/Not sure

8a) If yes, at what point in gestation did you become ill? _____ months/weeks (*circle*)

8b) If yes, did you experience any complications such as stillbirth, spontaneous abortion, or fetal

birth defects?

☐ Yes

☐ No

☐ Unknown/Not sure

8c) If yes to 8b, please specify: _____

9) (if applicable) Are you currently breastfeeding?

☐ Yes ☐ No

9a) (If yes to 9) Would you be willing to submit a sample of breast milk to test for Oropouche virus? [Make sure information is also recorded in the consent]

☐ Yes ☐ No

9b) (If yes to 9) Did your baby travel with you on the trip before your illness?

☐ Yes ☐ No

9c) (If yes to 9) Has your baby had any symptoms such as fever, loss of appetite, increased irritability, more sleepy, or rash since your illness (or around the time of your illness if the baby traveled)?

☐ Yes ☐ No ☐ Unknown/Not sure

☐ Other: _____

Note to interviewer: if their child has any worrisome symptoms, recommend they discuss with their pediatrician if Oropouche virus testing is appropriate.

10) If participant consented to sample collection and/or sexual history interview:

(if applicable) Have you had a vasectomy?

☐ Yes ☐ No ☐ Unknown/Not sure

10a) If yes, when? (approximate month and year) _____

10b) If yes, did you have the vasectomy reversed? ☐ Yes ☐ No ☐ Unknown/Not sure

10c) If reversed, when? (approximate month and year) _____

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

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

Finally, we are going to ask you some questions about travel and potential risks of exposure to Oropouche virus in the 2 weeks before your illness began.

12) During the 14 days before [initial symptom onset] were you traveling away from your home internationally?

☐ Yes ☐ No ☐ Unknown/not sure ☐ Prefer not to answer

13) During the 14 days before [initial symptom onset] were you traveling away from your home within the US?

☐ Yes ☐ No ☐ Unknown/not sure ☐ Prefer not to answer

14) If yes to Q8 or Q9, list **ALL** locations, including overnight transits and layovers:

Departure Date (MM/DD/YYYY)	Departure city, state/province/country	Arrival Date (MM/DD/YYYY)	Arrival city, state/province/country
Trip 1			
Trip 2			
Trip 3			
Trip 4			
Trip 5			

15) What **outdoor** activities did you do during your international trip? (in the 14 days before symptom onset) [Check all that apply]

☐ Sitting outdoors ☐ Walking ☐ Running ☐ Hunting / fishing ☐ Yard-work

☐ Hiking or camping ☐ Playing

☐ Other (specify) _____ ☐ Don't know

16) During what time periods did you typically spent more than 15 minutes outdoors doing these

types of activities during your trip?

15a) Early morning (4am to 8am)	C Yes	C No	C Don't know
15b) Daytime (8am to 5pm)	C Yes	C No	C Don't know
15c) Evening (5pm to 9pm)	C Yes	C No	C Don't know
15d) Nighttime (9pm to 4am)	C Yes	C No	C Don't know

17) During your travel, how many hours per day did you typically spend outside?

☐ <1 hour ☐ 1-4 hours ☐ 5-8 hours ☐ >8 hours

18) During your trip, in the 14 days before your illness began, do you recall any of the following?

Yes	No	Unknown	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Being bitten by a mosquito (If yes, fill out 18a)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Being bitten by a biting midge ("punkies" or "no-see-ums") (If yes, fill out 18b)

18a) What time(s) of day did you get bitten by mosquitoes? (Only if mosquito bites is yes)

Early morning (4am to 8am)	C Yes	C No	C Don't know
Daytime (8am to 5pm)	C Yes	C No	C Don't know
Evening (5pm to 9pm)	C Yes	C No	C Don't know
Nighttime (9pm to 4am)	C Yes	C No	C Don't know

18b) What time(s) of day did you get bitten by midges? (Only if biting midges is yes)

Early morning (4am to 8am)	C Yes	C No	C Don't know
Daytime (8am to 5pm)	C Yes	C No	C Don't know
Evening (5pm to 9pm)	C Yes	C No	C Don't know
Nighttime (9pm to 4am)	C Yes	C No	C Don't know

19) During your trip, how often did you do the following?

19a) When indoors, spent time in a place with screens or air-conditioning

C Always C Most of the time C Sometimes C Never C Don't know

19b) Wear long sleeves and long pants when outside

☐ Always ☐ Most of the time ☐ Sometimes ☐ Never ☐ Don't know

19c) Wear insect repellent when outdoors for 15 minutes or more

☐ Always ☐ Most of the time ☐ Sometimes ☐ Never ☐ Don't know

[If **NEVER** or **DK**, skip to Q.20]

19b.1) Do you recall the brand or active ingredient (such as DEET) of mosquito repellent that you usually use? _____ ☐ Don't know

20) During the 14 days before your illness, did you have close contact (e.g. caring for, speaking with, touching, or having sex) with anyone who was recently sick with a similar illness?

☐ Yes ☐ No ☐ Don't know

20a) If yes, can you describe any contact you had with that person?

☐ Physical contact ☐ Sexual contact ☐ In close proximity

☐ Other, describe: _____

Thank participants for their time and willingness to provide information to help us learn more about Oropouche virus disease.

APPENDIX F. FOLLOW-UP ABBREVIATED 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
Back pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Red eyes (conjunctival injection) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Retroorbital or eye pain <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

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

(retention) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> Not applicable <input type="radio"/> Recurrence, #: _____ OR <input type="radio"/> Ongoing symptom	(epididymitis, orchitis) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <input type="radio"/> 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:		

☐ Recurrence, #: _____ OR
☐ 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.