# ATTACHMENT 4. FOLLOW-UP ABBREVIATED CLINICAL SURVEY

*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 (0920-1446).*

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)  o Yes o No o Unknown  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | Painful ejaculation  o Yes o No o Unknown o Not applicable  o Recurrence, #: \_\_\_\_\_\_ OR  o Ongoing symptom | | Scrotal and/or testicular pain (epididymitis, orchitis)  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.***