Flu-Related Symptoms Questionnaire

Hello, this is ?

I am a member of the research team at and I am calling to see if you have time to complete a survey for the CSP#2028: EPIC3 study. This survey will take about 10 minutes to complete, and I will ask questions about any symptoms you may be experiencing.

Is now a good time to get started?

IF No - When would be a better time for me to call back?

IF Yes - Thank you! Please keep in mind that your participation is voluntary, and as we go through the survey, you may refuse to answer any questions. Your responses will be kept confidential and secure according to VA policy. Please let me know if you need a break from answering questions at any time. Complete Flu-Related Symptoms Questionnaire with participant.

Survey date: _____

SECTION A

1. What is your name?

INTERVIEWER: Was the participant able to correctly identify their first name, last name, or both?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

2. What is today's date?

INTERVIEWER: Was the participant able to correctly identify the year, month and day?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

3. What country are we currently in?

INTERVIEWER: Was the participant able to correctly identify the United States?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

4. INTERVIEWER: Is the participant currently admitted as an inpatient?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

5. INTERVIEWER ASK PRIMARY CARE TEAM OR CONSULT THEIR MEDICAL NOTES TO ANSWER THE FOLLOWING SET OF QUESTIONS:

What type of supplemental oxygenation treatment is the patient currently receiving (choose one)?

- ◯ Room air
- ◯ Nasal cannula OR other non-high flow, non-positive pressure delivery system (e.g., face mask, face tent, venturi mask, and non-rebreather)
- ◯ High flow oxygen OR non-invasive ventilation (BiPAP or CPAP)
- ◯ Mechanical ventilation
- ◯ Unable to be determined from care team and/or their medical notes
- ◯ Interviewer was unable to assess this question

6. What is the last measured flow rate?

_____
(LPMEnter 888 if unknown/unreported.)

7. What is the last measured FiO2%?

_____
(%Enter 888 if unknown/unreported.)

SECTION B

Please rate the extent to which you had each symptom during the past 24 hours.

	Not at all	A little bit	Somewhat	Quite a bit	Very much	Prefer not to answer
Runny or dripping nose	○	○	○	○	○	○
Congested or stuffy nose	○	○	○	○	○	○
Sinus pressure	○	○	○	○	○	○
Scratchy or itchy throat	○	○	○	○	○	○
Sore or painful throat	○	○	○	○	○	○
Difficulty swallowing	○	○	○	○	○	○
Teary or watery eyes	○	○	○	○	○	○
Sore or painful eyes	○	○	○	○	○	○
Eyes sensitive to light	○	○	○	○	○	○
Trouble breathing	○	○	○	○	○	○
Chest congestion	○	○	○	○	○	○
Chest tightness	○	○	○	○	○	○
Dry or hacking cough	○	○	○	○	○	○
Wet or loose cough	○	○	○	○	○	○
Felt nauseous (feeling like you wanted to throw up)	○	○	○	○	○	○
Stomach ache	○	○	○	○	○	○
Felt dizzy	○	○	○	○	○	○
Head congestion	○	○	○	○	○	○
Headache	○	○	○	○	○	○
Lack of appetite	○	○	○	○	○	○
Sleeping more than usual	○	○	○	○	○	○
Body aches or pains	○	○	○	○	○	○
Weak or tired	○	○	○	○	○	○
Chills or shivering	○	○	○	○	○	○
Felt cold	○	○	○	○	○	○
Felt hot	○	○	○	○	○	○
Sweating	○	○	○	○	○	○

In the past 24 hours, how often have you had any of the following symptoms?

	Never	Rarely	Sometimes	Often	Always	Prefer not to answer
Sneezing	◯	◯	◯	◯	◯	◯
Coughing	◯	◯	◯	◯	◯	◯
Coughed up mucus or phlegm	◯	◯	◯	◯	◯	◯

	0 times	1 time	2 times	3 times	4 or more times	Prefer not to answer
How many times did you vomit?	◯	◯	◯	◯	◯	◯
How many times did you have diarrhea?	◯	◯	◯	◯	◯	◯

	No	Yes	Prefer not to answer
In the past 24 hours, did you have any of the following symptoms?	◯	◯	◯
Loss of smell Loss of taste	◯	◯	◯

1. Did you take any medication for your infection symptoms today?
◯ Yes
◯ No
◯ Prefer not to answer

2. Do you have asthma, COPD (chronic obstructive pulmonary disease) or both?
◯ Yes
◯ No
◯ Prefer not to answer

3. Did you use any rescue medication today for your asthma or COPD?
◯ Yes
◯ No
◯ Prefer not to answer

4. Overall, how severe were your infection symptoms today?
◯ No flu symptoms today
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ Prefer not to answer

5. Overall, how were your infection symptoms today compared to yesterday?
◯ Much better
◯ Somewhat better
◯ A little better
◯ About the same
◯ A little worse
◯ Somewhat worse
◯ Much worse
◯ Prefer not to answer

6. How much did your flu symptoms interfere with your usual activities today?
◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ Prefer not to answer

7. Have you returned to your usual activities today?
◯ Yes
◯ No
◯ Prefer not to answer

8. In general, how would you rate your physical health today?	◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor ◯ Prefer not to answer
9. Have you returned to your usual health today?	◯ Yes ◯ No ◯ Prefer not to answer
INTERVIEWER: WOULD YOU LIKE TO PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE?	◯ Yes ◯ No
INTERVIEWER: PLEASE PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE.	_____ (Do not enter identifiable information into notes box.)