

Patient symptom survey

Patient number:

Assessment Time Point:

Did you have a fever > 100.4 F (38C): Yes or No

No feeling
of fever
(subjective
fever)

0 1 2 3 4 5 6 7 8 9 10

Worst
possible
fever

Number of
days with
a fever

No feeling
of chills

0 1 2 3 4 5 6 7 8 9 10

Worst
possible
chills

Number of
days with
chills

No feeling
of muscle
aches

0 1 2 3 4 5 6 7 8 9 10

Worst
possible
muscle
aches

Number of
days with
muscle
aches

No runny
nose

0 1 2 3 4 5 6 7 8 9 10

Worst
possible
runny
nose

Number of
days with
a runny
nose

No feeling of sore throat	<hr/> <p>0 1 2 3 4 5 6 7 8 9 10</p>	Worst feeling of sore throat	Number of days with a sore throat <input type="text"/>
No cough (new onset or worsening of chronic cough)	<hr/> <p>0 1 2 3 4 5 6 7 8 9 10</p>	Worst possible cough	Number of days with a cough <input type="text"/>
No shortness of breath	<hr/> <p>0 1 2 3 4 5 6 7 8 9 10</p>	Worst possible shortness of breath	Number of days with shortness of breath <input type="text"/>
No feeling of nausea	<hr/> <p>0 1 2 3 4 5 6 7 8 9 10</p>	Worst possible nausea	Number of days with nausea <input type="text"/>
No vomiting	<hr/> <p>0 1 2 3 4 5 6 7 8 9 10</p>	Worst possible vomiting	Number of days with vomiting <input type="text"/>

No headache	0	1	2	3	4	5	6	7	8	9	10	Worst possible headache	Number of days with headache
	<hr/>												<input type="text"/>
No abdominal pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible abdominal pain	Number of days with abdominal pain
	<hr/>												<input type="text"/>
No diarrhea (>3 loose stools/24 hrs)	0	1	2	3	4	5	6	7	8	9	10	Worst possible diarrhea	Number of days with diarrhea
	<hr/>												<input type="text"/>
No loss of taste/smell	0	1	2	3	4	5	6	7	8	9	10	Worst possible loss of taste/smell	Number of days with loss of taste/smell
	<hr/>												<input type="text"/>
No chest tightness	0	1	2	3	4	5	6	7	8	9	10	Worst possible chest tightness	Number of days with chest tightness
	<hr/>												<input type="text"/>

