



Clinic:  

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Participant ID:  

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Nickname:  

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Outcome Visit:  

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Month:  

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Day:  

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Year:  

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<b>Did you have (please fill in all days that apply)</b>	<b>No days</b>	<b>Yester day</b>	<b>2 days ago</b>	<b>3 days ago</b>
c. a headache?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. dizziness, earache, or ringing in your ears?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. difficulty hearing, or discharge, or bleeding from an ear?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. stuffy or runny nose, or bleeding from the nose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. a sore throat, difficulty swallowing, or hoarse voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. a tooth ache or jaw pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. sore or bleeding lips, tongue, or gums?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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