

DAILY

Enter the participant number assigned by the study staff. It should have 5 characters, a hyphen, and four digits (e.g. Y0401-0001) _____	Date of birth [][][][][][]/[][][][][][]/[][][][][][]
---	---

DAILY ASSESSMENT

DATE OF ASSESSMENT [][][][][][]/[][][][][][]/[][][][][][]	
Did you measure your temperature today? <input type="radio"/> Yes <input type="radio"/> No	If Yes: What was the highest temperature you measured today _____ <input type="radio"/> °C <input type="radio"/> °F
Did you measure your oxygen saturation today? <input type="radio"/> Yes <input type="radio"/> No	If Yes: What was the lowest oxygen saturation value you measured today (%) _____

SYMPTOMS: Indicate if experienced between 00:00 to 24:00 on day of assessment.

In the previous 24 hours, did you experience any of the symptoms below?			
Fever <input type="radio"/> Yes <input type="radio"/> No	Chills or rigors <input type="radio"/> Yes <input type="radio"/> No	Fatigue / malaise / lethargy <input type="radio"/> Yes <input type="radio"/> No	
Weakness <input type="radio"/> Yes <input type="radio"/> No	Muscle aches (myalgia) <input type="radio"/> Yes <input type="radio"/> No	Skin rash <input type="radio"/> Yes <input type="radio"/> No	
Back Pain <input type="radio"/> Yes <input type="radio"/> No	Neck Pain <input type="radio"/> Yes <input type="radio"/> No		
Cough <input type="radio"/> Yes <input type="radio"/> No	If Yes: Cough type <input type="radio"/> Non Productive (dry cough) <input type="radio"/> Productive (wet cough) <input type="radio"/> Haemoptysis (coughing up blood) <input type="radio"/> Unknown		
Shortness of breath <input type="radio"/> Yes <input type="radio"/> No	Chest pain <input type="radio"/> Yes <input type="radio"/> No	Abdominal pain (stomach pain) <input type="radio"/> Yes <input type="radio"/> No	
Diarrhoea <input type="radio"/> Yes <input type="radio"/> No	Vomiting <input type="radio"/> Yes <input type="radio"/> No	Nausea <input type="radio"/> Yes <input type="radio"/> No	
Anorexia (lack of appetite) <input type="radio"/> Yes <input type="radio"/> No	Urinary retention <input type="radio"/> Yes <input type="radio"/> No	Increased urination (polyuria) <input type="radio"/> Yes <input type="radio"/> No	
Bleeding (haemorrhage) <input type="radio"/> Yes <input type="radio"/> No		If Yes: Severe bleeding (requiring the intervention of a health care provider) <input type="radio"/> Yes <input type="radio"/> No	
Headache <input type="radio"/> Yes <input type="radio"/> No	Photophobia (aversion to light) <input type="radio"/> Yes <input type="radio"/> No	Hazy / Blurred vision <input type="radio"/> Yes <input type="radio"/> No	
Seizures / convulsions <input type="radio"/> Yes <input type="radio"/> No		Altered consciousness / confusion <input type="radio"/> Yes <input type="radio"/> No	
Other symptom(s) <input type="radio"/> Yes <input type="radio"/> No		If Yes: _____	

WELLBEING QUESTIONS	
Please read each statement and indicate how you feel right now, in this moment.	
I feel calm	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Moderately <input type="radio"/> Very much <input type="radio"/> Prefer not to answer
I am tense	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Moderately <input type="radio"/> Very much <input type="radio"/> Prefer not to answer
I feel upset	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Moderately <input type="radio"/> Very much <input type="radio"/> Prefer not to answer
I am relaxed	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Moderately <input type="radio"/> Very much <input type="radio"/> Prefer not to answer
I feel content	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Moderately <input type="radio"/> Very much <input type="radio"/> Prefer not to answer
I am worried	<input type="radio"/> Not at all <input type="radio"/> Somewhat <input type="radio"/> Moderately <input type="radio"/> Very much <input type="radio"/> Prefer not to answer
How would you rate your health today?	<input type="radio"/> Excellent <input type="radio"/> Very good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor <input type="radio"/> Prefer not to answer
How likely do you think it is that you will develop symptoms of hantavirus?	<input type="radio"/> Very likely <input type="radio"/> Fairly likely <input type="radio"/> Not very likely <input type="radio"/> Not at all likely <input type="radio"/> Prefer not to answer
How serious do you think it would be for you if you were to develop symptoms of hantavirus?	<input type="radio"/> Very serious <input type="radio"/> Fairly serious <input type="radio"/> Slightly serious <input type="radio"/> Not very serious <input type="radio"/> Not at all serious <input type="radio"/> Prefer not to answer
Please indicate how much you agree or disagree with this statement: There are people I can depend on to help me if I really need it.	<input type="radio"/> Strongly agree <input type="radio"/> Agree <input type="radio"/> Disagree <input type="radio"/> Strongly disagree <input type="radio"/> Prefer not to answer