

## Symptom Diary After Smallpox Vaccination

- a) Patient name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_      b) Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- c) Date of Birth: Mo \_\_\_\_/Day \_\_\_\_/Yr \_\_\_\_\_      d) Age: \_\_\_\_ years      e) Gender:  Male  Female
- f) Date of smallpox vaccine administration: Mo \_\_\_\_/Day \_\_\_\_/Yr \_\_\_\_\_      g) Clinic / site where vaccination was given: \_\_\_\_\_
- h) Taken any steroids/pain/fever medications:  1-3 days before vaccine(\_\_\_\_\_)  0-30 days after vaccine(\_\_\_\_\_)  None during this period (-3 to +30 days)
- i) Ethnicity  White/Caucasian  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  
 Hispanic  American Indian/Alaskan Native  Do not want to provide  Other (specify: \_\_\_\_\_)

<b>THE FIRST 4 WEEKS AFTER SMALLPOX VACCINATION:</b> Please <b>check any symptoms</b> present on each indicated day recording details below	Day 0 = vaccination	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Week 4
1. Symptoms (Y or N)																						
2. Fever (record temperature, eg, 101.2F)																						
3. Chills (Y or N)																						
4. Swelling at vaccination site (Y or N)																						
5. Cough/difficulty breathing (Y or N)																						
6. Rash or reaction on body (Y or N. If Y, describe rash and where below)																						
7. Bandage used (Y or N, type below)																						
8. Did you seek medical care <u>because of vaccination?</u> (describe below)																						
9. Did you take any medications <u>because of vaccination?</u> (specify below)																						
10. Did you miss work/school <u>because of vaccination?</u>																						
11. Joint pain (0-9 scale) (0=no, 9=worst)																						
12. Muscle pain (0-9 scale)																						
13. Headache (0-9 scale)																						
14. Pain at vaccination site (0-9 scale)																						
15. Swelling/tender lymph nodes (0-9)																						
16. Itching at vaccination site (0-9 scale)																						
17. Chest pain (0-9 scale)																						
18. Other symptoms, illnesses, new medications, etc. (describe below)																						
19. <b>Vaccination site appearance</b> (using letter codes below)																						

**Date scab fell off:** Mo \_\_\_\_/Day \_\_\_\_/Yr \_\_\_\_\_      **If medical care sought, where?** \_\_\_\_\_      Permission to acquire medical records?  Yes  No

**Use all the letter codes that apply to describe vaccination site for each day above:** Name of facility/MD: \_\_\_\_\_

1 = red spot     2 = bump     3 = reddish blister     4 = whitish blister     5 = scab    Address: \_\_\_\_\_  
 6 - ulcer, crater     W - warmth     Sw -swollen > 3 in.     St = streaks     Dr = drainage    City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Additional comments (use additional pages if necessary):** \_\_\_\_\_

Signature of vaccinee: _____	Date completed: _____
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DATA PRIVACY NOTICE: Data requested are being collected under the authority of the Privacy Act of 1974, 5 U.S.C. § 552A. The SSN is being collected because it is a unique identifier that will better enable military staff to maintain contact with patients over time. Every effort will be made to safeguard the confidentiality of the information provided.