



Protocol: XXX-XX-NNN

Visit

Subject Initials: Subject No.:

See page 2 of this document for guidelines of which SDC to use

Symptom Diary Card

Date

dd mmm yyyy

Time :

hh mm

Morning Afternoon Evening

Symptoms Please report the highest level of symptoms you have experienced since completing the last diary card (if applicable), including any symptoms you currently have (tick ONE in each row)	I have NO symptoms	Just noticeable	It's clearly bothersome from time-to-time, but it doesn't interfere with me doing my normal daily activities	It's quite bothersome most or all of the time, and it stops me from participating in activities
Runny Nose	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Stuffy Nose	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Sneezing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Sore Throat	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Earache	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Malaise/Tiredness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Headache	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Muscle and/or Joint Ache	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Chilliness/Feverishness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Cough	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Shortness of breath	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Volunteer's Initials _____



Protocol: XXX-XX-NNN Visit

Subject Initials:










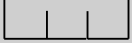



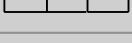





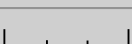





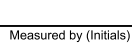
Subject No.:

Symptom Diary Card

Morning

Afternoon

Evening

Symptoms Please report the highest level of symptoms you have experienced since completing the last diary card (if applicable), including any symptoms you currently have	Mark the scale with a single line as demonstrated below:  Less severe symptom  More severe symptom 	Line Length (mm):  Length of mark (mm):
Runny Nose		
Stuffy Nose		
Sneezing		
Sore Throat		
Earache		
Malaise/ Tiredness		
Headache		
Muscle and/ or Joint Ache		
Chilliness/ Feverishness		
Cough		
Shortness of breath		
Volunteer's Initials <input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/> DD MMM YYYY at HH : MM Physician Initials dd mmm yyyy hh mm	Measured by (Initials) <input style="width: 100%; height: 20px;" type="text"/> DD MMM YYYY dd mmm yyyy