Compound	Protocol	Visit
MK-4482	**019**	

Screening No. *(Site - Sequence No.)*	Randomization No.
__ __ __ __-__ __ __ __ __	__ __ __ __ __ __

FLU-PRO Plus

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Specify completion date: _____ ***(Start)*** Time: ____: ____ 24-hr clock
DD-Mon-YYYY HR MIN

Comments:

Scheduled Time: ***(Please check one)*** ☐ Day -1 ☐ Day 0 PREDOSE ☐ Day 0 CHALLENGE
☐ Day 0 POSTDOSE ☐ Day 1 ☐ Day 2 ☐ Day 3
☐ Day 4 ☐ Day 5 ☐ Day 6 ☐ Day 7

Only the participant should enter information onto this questionnaire.

People experience viral respiratory tract infections in different ways. We would like to know about the symptoms you have been experiencing during the past 24 hours. For each symptom, please mark one box ☐ under the response that best matches your experience. Mark the "Not at all" box, if you did not have that symptom in the past 24 hours.

What time is it? _____AM / PM (please circle)

Please rate the extent to which you had each symptom during the past 24 hours.

	Not at all	A little bit	Somewhat	Quite a bit	Very much
Runny or dripping nose	☐	☐	☐	☐	☐
Congested or stuffy nose	☐	☐	☐	☐	☐
Sinus pressure	☐	☐	☐	☐	☐
Scratchy or itchy throat	☐	☐	☐	☐	☐
Sore or painful throat	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐
Teary or watery eyes	☐	☐	☐	☐	☐
Sore or painful eyes	☐	☐	☐	☐	☐
Eyes sensitive to light	☐	☐	☐	☐	☐
Trouble breathing	☐	☐	☐	☐	☐
Chest congestion	☐	☐	☐	☐	☐
Chest tightness	☐	☐	☐	☐	☐
Dry or hacking cough	☐	☐	☐	☐	☐
Wet or loose cough	☐	☐	☐	☐	☐
Felt nauseous (feeling like you wanted to throw-up)	☐	☐	☐	☐	☐
Stomach ache	☐	☐	☐	☐	☐

I have reviewed this information.	Staff Initials:	Date:

A PHASE 2A DOUBLE-BLIND, RANDOMIZED, PLACEBO-CONTROLLED STUDY TO EVALUATE THE EFFICACY AND SAFETY OF MK-4482 IN HEALTHY PARTICIPANTS INOCULATED WITH EXPERIMENTAL INFLUENZA VIRUS

FLUPP2-2

Compound	Protocol	Visit
MK-4482	**019**	

Screening No. *(Site - Sequence No.)*	Randomization No.
__ __ __ __-__ __ __ __ __	__ __ __ __ __ __

Please rate the extent to which you had each symptom during the past 24 hours.

FLU-PRO Plus					
	Not at all	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
Felt dizzy	☐	☐	☐	☐	☐
Head congestion	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐
Lack of appetite	☐	☐	☐	☐	☐
Sleeping more than usual	☐	☐	☐	☐	☐
Body aches or pains	☐	☐	☐	☐	☐
Weak or tired	☐	☐	☐	☐	☐
Chills or shivering	☐	☐	☐	☐	☐
Felt cold	☐	☐	☐	☐	☐
Felt hot	☐	☐	☐	☐	☐
Sweating	☐	☐	☐	☐	☐

In the past 24 hours, how often have you had any of the following symptoms?

	Never	**Rarely**	**Sometimes**	**Often**	**Always**
Sneezing	☐	☐	☐	☐	☐
Coughing	☐	☐	☐	☐	☐
Coughed up mucus or phlegm	☐	☐	☐	☐	☐

	0 times	**1 time**	**2 times**	**3 times**	**4 or more times**
How many times did you vomit?	☐	☐	☐	☐	☐
How many times did you have diarrhea?	☐	☐	☐	☐	☐

In the past 24 hours, did you have any of the following symptoms?

	No	**Yes**
Loss of smell	☐	☐
Loss of taste	☐	☐

I confirm this information is accurate.	Participant Initials:	Date:
I have reviewed this information.	Staff Initials:	Date: