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FORM APPROVED
BUDGET BUREAU NO. 68-R1009

INFLUENZA EPIDEMIC QUESTIONNAIRE

NAME: ______________________________ AGE: ______ SEX: [] Male [] Female
(Last Name) First Name) (Mid. Initial)

SCHOOL: ______________________________ GRADE: __________ DATE: __________

	YES	NO	DON'T KNOW
I. Have you had a flu shot since September 1, 1968?	[]	[]	[]
If YES, please answer the following:			
A. Did you get it at school?	[]	[]	
B. Did you get it from your family doctor?	[]	[]	

Influenza ("flu") is commonly described as a respiratory illness, often, but not always, associated with fever. The symptoms of "flu" include headache, muscle aching, scratchy throat, cough, stuffy nose, runny nose, a general feeling of being "sick all over," and occasionally nausea and vomiting. Any or all of these symptoms may be present in a case of "flu."

	YES	NO	DON'T KNOW
II. Have you had influenza ("flu") since December 1, 1968? . . .	[]	[]	[]
If YES, please complete each of the following:			
A. Did it start between December 1 and December 20?	[]	[]	[]
B. Did it start between December 21 and January 6?	[]	[]	[]

C. Approximate date of onset of illness ______________

D. Circle each day you were ill on the calendars below. Also put an "X" through those days on which you were absent from school due to illness.

December 1968

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January 1969

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 1969

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

	YES	NO	DON'T KNOW
E. Did you have a fever?	[]	[]	[]
Did you have chills?	[]	[]	[]
F. Was your temperature taken with a thermometer? . .	[]	[]	
If YES, what was the highest reading? ________ °F.			[]-Don't Know

G. Describe your illness by checking the appropriate boxes below:

1. Type of Onset: SUDDEN []; GRADUAL []; UNSURE OF ONSET [].
2. Duration of Illness: 1-3 Days []; 4-7 Days []; 8+ Days [].
3. SYMPTOMS: (Check each symptom which you had and put a star beside the most prominent symptom.)

[] Malaise ("sick all over")
[] Dizziness
[] Headache
[] Muscle aching
[] Eye pain
[] Sweats

[] Fever
[] Chills
[] Hoarseness
[] Cough
[] Runny Nose
[] Sore Throat

[] Chest pain
[] Loss of appetite
[] Nausea
[] Vomiting
[] Abdominal pain
[] Diarrhea
OTHER: ______________________

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