



UNIVERSAL Trial Case Report Form

Participant Trial Number [grid]

Patient Initials [grid]

Date Completed (DD/MMM/YYYY) [grid]

FLU-PRO Plus®

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.

Table with 6 columns: Symptom, Not at all, A little bit, Somewhat, Quite a bit, Very much. Rows include 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.

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	Not at all	A little bit	Somewhat	Quite a bit	Very much
Trouble breathing	<input type="checkbox"/>				
Chest congestion	<input type="checkbox"/>				
Chest tightness	<input type="checkbox"/>				
Dry or hacking cough	<input type="checkbox"/>				
Wet or loose cough	<input type="checkbox"/>				

Felt nauseous (feeling like you wanted to throw-up)	<input type="checkbox"/>				
Stomach ache	<input type="checkbox"/>				

Felt dizzy	<input type="checkbox"/>				
Head congestion	<input type="checkbox"/>				
Headache	<input type="checkbox"/>				

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
Lack of appetite	<input type="checkbox"/>				
Sleeping more than usual	<input type="checkbox"/>				
Body aches or pains	<input type="checkbox"/>				
Weak or tired	<input type="checkbox"/>				
Chills or shivering	<input type="checkbox"/>				
Felt cold	<input type="checkbox"/>				
Felt hot	<input type="checkbox"/>				
Sweating	<input type="checkbox"/>				

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

	Never	Rarely	Sometimes	Often	Always
Sneezing	<input type="checkbox"/>				
Coughing	<input type="checkbox"/>				
Coughed up mucus or phlegm	<input type="checkbox"/>				

	0 times	1 time	2 times	3 times	4 or more times
How many times did you vomit?	<input type="checkbox"/>				
How many times did you have diarrhea?	<input type="checkbox"/>				

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

	No	Yes
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>