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:_____)

THE FIRST 4 WEEKS AFTER SMALLPOX VACCINATION: Please **check any symptoms** 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 vaccine-type 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 (0-9scale) (0=no, 9=worse)																						
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 scale)																						
16. Itching at vaccination site (0-9 scale)																						
17. Chest pain (0-9 scale)																						
18. Shortness of breath (0-9 scale)																						
19. Other symptoms, illnesses, new medications, etc.(describe below)																						
20. **Vaccination site appearance** (using letter codes below)																						

Date scab fell off: Mo_____/Day_____/Yr_____

If at any time you have questions about your vaccination please contact the DoD Vaccine Clinical Call Center at 1-866-210-6469 (24 hrs a day, 7 days a week) or email the Vaccine Healthcare Center at https://askvhc.wramc.amedd.army.mil

Use all the letter codes that apply to describe vaccination site for each day above:

1= red spot	2= bump	3=reddish blister	4=whitish blister	5=scab
6=ulcer, crater	w=warmth	sw=swollen>3 in.	st=streaks	dr=drainage

If medical care sought, where? Name of facility/MD: _____

Permission to acquire medical records? ☐ **Yes** ☐ **No**

Additional comments (use additional pages if necessary): _____

_____

_____

Signature of vaccinee:	**Date completed:**

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.

07 Feb 08