Symptom Diary Card

Subject Number	Subject Initials	Date	Time (24 hour clock)	Time of Day (mark with an X)		
	F M L	D D M M M Y Y Y Y	H H : M M	Morning	Afternoon	Evening

Level	0	1	2	3
Symptoms Please report the symptoms you are experiencing at the moment (Mark with an ×)	I have NO symptoms	Just noticeable	It's clearly bothersome from time to time, but it doesn't stop me from participating in activities	It's quite bothersome most or all of the time, and it stops me from participating in activities
Runny Nose	☐ 0	☐ 1	☐ 2	☐ 3
Stuffy Nose	☐ 0	☐ 1	☐ 2	☐ 3
Sneezing	☐ 0	☐ 1	☐ 2	☐ 3
Sore Throat	☐ 0	☐ 1	☐ 2	☐ 3
Earache	☐ 0	☐ 1	☐ 2	☐ 3
Malaise (tiredness)	☐ 0	☐ 1	☐ 2	☐ 3
Cough	☐ 0	☐ 1	☐ 2	☐ 3
Shortness of breath	☐ 0	☐ 1	☐ 2	☐ 3
Headache	☐ 0	☐ 1	☐ 2	☐ 3
Muscle and/or joint ache	☐ 0	☐ 1	☐ 2	☐ 3

Subject's initials	Doctor's initials	Date	Time (24 hour clock)
		D D M M M Y Y Y Y	H H : M M

hVIVO