SOCIODEMOGRAPHIC DATA

Record ID _____

CRF – Socio-demographic Information

Date of visit: _____

Date of birth: _____

Age _____

Sex: ○ Female ○ Male

Point of care: _____

Place of birth

State:

○ Acre ○ Alagoas ○ Amapá
○ Amazonas ○ Bahia
○ Ceará ○ Distrito Federal
○ Espírito Santo ○ Goiás
○ Maranhão ○ Mato Grosso
○ Mato Grosso do Sul ○ Minas Gerais
○ Pará ○ Paraíba ○ Paraná
○ Pernambuco ○ Piauí
○ Rio de Janeiro ○ Rio Grande do Norte
○ Rio Grande do Sul ○ Rondônia
○ Roraima ○ Santa Catarina
○ São Paulo ○ Sergipe
○ Tocantins

City: _____

Country:

- Afghanistan
- South Africa
- Akrotiri
- Albania
- Germany
- Andorra
- Angola
- Anguila
- Antarctica
- Antígua and Barbuda
- Saudi Arabia
- Arctic Ocean
- Algeria
- Argentina
- Armenia
- Arruba
- Ashmore and Cartier Islands
- Atlantic Ocean
- Australia
- Áustria
- Azerbaijan
- Bahamas
- Bangladesh
- Barbados
- Bahrain
- Belgium
- Belize
- Benim
- Bermudas
- Bielorrussia
- Burma
- Bolivia
- Bosnia and Herzegovina
- Botswana
- Brazil
- Brunei
- Bulgaria
- Burkuina Faso
- Burundi
- Butan
- Cape Verde
- Camaroons
- Cambodia
- Canada
- Quatar
- Kazakhstan
- Chad
- Chile
- China
- Cyprus
- Clipperton Island
- Colombia
- Comoros
- Congo-Brazzaville
- Congo-Kinshasa
- Coral Sea Islands
- North Korea
- South Korea
- Ivory Coast
- Costa Rica
- Croacia
- Cuba
- Curacao
- Dhekelia
- Denmark
- Dominican Rep.
- Egypt
- United Arab Emirates
- Equador
- Eritrea
- Slovakia
- Slovenia
- Spain
- United States
- Estonia
- Ethiopia
- Faroe Islands
- Fiji
- Philippines
- Finland
- France
- Gabon
- Gambia
- Ghana
- Gaza Strip
- Georgia
- South Geórgia and South Sandwich
- Gibraltar
- Granada
- Greece
- Greenland
- Guam
- Guatemala
- Guernsey
- Guyana
- Guinea
- Equatorial Guinea
- Guinea Bissau
- Haiti
- Honduras
- Hong Kong
- Hungary
- Yemen
- Bouvet Is.
- Christmas Is.
- Norfolk Is.
- Cayman Is.
- Cook Is.
- Cocos Islands
- Falkland Is.
- Heard and McDonald
- Marshall Islands
- Solomon Islands
- Turks and Caicos Islands
- US Virgin Islands
- Ilhas Virgens Britânicas
- India
- Indian Ocean
- Indonesia
- Iran
- Iraq
- Ireland
- Island
- Israel
- Italy
- Jamaica
- Jan Mayen
- Japan
- Jersey
- Djibouti
- Jordan
- Kosovo
- Kuwait
- Laos
- Lesotho
- Latvia
- Lebanon
- Liberia
- Libya
- Liechtenstein
- Lithuania
- Luxembourg
- Macao
- Macedonia
- Madagascar
- Malaysia

○ Malawi ○ Maldives

Mali
Malta
Isle of
Northern Marianas
Morocco
Mauritius
Mauritania
Mexico
Micronesia
Mozambique
Moldavia
Monaco
Mongolia
Monserrat
Montenegro
Namibia
Nauru
Navassa Island
Nepal
Nicaragua
Niger
Nigeria
Niue
Norway
New Caledonia
New Zealand
Oman
Pacific Ocean
Netherlands
Palau
Panama
Papua-New Guinea
Pakistan
Paracel Islands
Paraguay
Peru
Pitcairn
French Polynesia
Poland
Porto Rico
Portugal
Kenya
Kyrgyzstan
Kiribati
UK
Central African Republic
Dominican
Czech Republic
Republic
Romania
Rwanda
Russia
Salvador
Samoa
American Samoa
Saint Helena
St. Lucia
St. Bartholomew
St. Kitts and
Neves
San Marino
Saint Martin
St. Pierre e Miquelon
São Tomé and Príncipe
St. Vincent and Grenadines
Western Sahara
Seychelles
Senegal
Sierra Leone
Serbia
Singapore
Sint Maarten
Syria
Somalia
Southern Ocean
Spratly Islands
Sri Lanka
Swaziland
Sudan
South Sudan
Sweden
Switzerland
Suriname
Svalbard and Jan Mayen
Thailand
Taiwan
Tajikistan
Tanzania
British Indian Ocean Territory
French Southern Territories
East Timor
Togo
Tokelau
Tonga
Trindade and
Tobago
Tunisia
Turkmenistan
Turkey
Tuvalu
Ucrânia
Uganda
European Union
Uruguay
Uzbekistan
Vanuatu
Vatican City
Venezuela
Vietnam
Wake Island
Wallis and Futuna
West Bank
Zambia
Zimbabwe

Skin color:

White
Black
Brown
Yellow
Other

If other, state:

_____

Profession: _____

Education Level:

- ◯ Illiterate
- ◯ Finished Elementary School
- ◯ Did not finish Elementary School
- ◯ Finished High School
- ◯ Did not finish High School
- ◯ Finished University Degree
- ◯ Did not finish University Degree
- ◯ Does not know or does not wish to answer

Marital Status:

- ◯ Single
- ◯ Living together
- ◯ Divorced
- ◯ Married
  - ◯ Widow(er)
  - ◯ Separated

HISTORY OF MEDICATION

CRF - Medication History

Have you taken any medication in the last 15 days? ○ Yes ○ No

How many different medicines?

○ 1
○ 2
○ 3
○ 4
○ 5
○ 6
○ 7
○ 8
○ 9
○ 10

Medication 1

Generic Name: _____

Amount (mg/mL): _____

Dosage: _____

Duration of Treatment (days): _____

Therapeutic Indication: _____

Medication prescribed by doctor or dentist: ○ Yes ○ No

How many days did the participant take this medicine in the last two weeks? _____

Did the participant present proof of use of the medication? ○ Yes ○ No
(Packaging, package insert, prescription)

Medication 2

Generic Name: _____

Amount (mg/mL): _____

Dosage: _____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Medication prescribed by doctor or dentist: ◯ Yes ◯ No

How many days did the participant take this medicine in the last two weeks?

_____

Did the participant present proof of use of the medication? ◯ Yes ◯ No
(Packaging, package insert, prescription)

Medication 3

Generic Name:

_____

Amount (mg/mL):

_____

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Medication prescribed by doctor or dentist: ◯ Yes ◯ No

How many days did the participant take this medicine in the last two weeks?

_____

Did the participant present proof of use of the medication? ◯ Yes ◯ No
(Packaging, package insert, prescription)

Medication 4

Generic Name:

_____

Amount (mg/mL):

_____

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Medication prescribed by doctor or dentist:	○ Yes ○ No
How many days did the participant take this medicine in the last two weeks?	_____
Did the participant present proof of use of the medication?	○ Yes ○ No (Packaging, package insert, prescription)

Medication 5

Generic Name:	_____
Amount (mg/mL):	_____
Dosage:	_____
Duration of Treatment (days):	_____
Therapeutic Indication:	_____
Medication prescribed by doctor or dentist:	○ Yes ○ No
How many days did the participant take this medicine in the last two weeks?	_____
Did the participant present proof of use of the medication?	○ Yes ○ No (Packaging, package insert, prescription)

Medication 6

Generic Name:	_____
Amount (mg/mL):	_____
Dosage:	_____
Duration of Treatment (days):	_____
Therapeutic Indication:	_____
Medication prescribed by doctor or dentist:	○ Yes ○ No
Did the participant present proof of use of the medication?	_____

Did the participant present proof of use of the medication?	◯ Yes ◯ No (Packaging, package insert, prescription)

Medication 7

Generic Name:	_____
Amount (mg/mL):	_____
Dosage:	_____
Duration of Treatment (days):	_____
Therapeutic Indication:	_____
Medication prescribed by doctor or dentist:	◯ Yes ◯ No
How many days did the participant take this medicine in the last two weeks?	_____
Did the participant present proof of use of the medication?	◯ Yes ◯ No (Packaging, package insert, prescription)

Medication 8

Generic Name:	_____
Amount (mg/mL):	_____
Dosage:	_____
Duration of Treatment (days):	_____
Therapeutic Indication:	_____
Medication prescribed by doctor or dentist:	◯ Yes ◯ No
How many days did the participant take this medicine in the last two weeks?	_____
Did the participant present proof of use of the medication?	◯ Yes ◯ No (Packaging, package insert, prescription)

Medication 9

Generic Name: _____

Amount (mg/mL): _____

Dosage: _____

Duration of Treatment (days): _____

Therapeutic Indication: _____

Medication prescribed by doctor or dentist: ○ Yes ○ No

How many days did the participant take this medicine in the last two weeks? _____

Did the participant present proof of use of the medication? ○ Yes ○ No
(Packaging, package insert, prescription)

Medication 10

Generic Name: _____

Amount (mg/mL): _____

Dosage: _____

Duration of Treatment (days): _____

Therapeutic Indication: _____

Medication prescribed by doctor or dentist: ○ Yes ○ No

How many days did the participant take this medicine in the last two weeks? _____

Did the participant present proof of use of the medication? ○ Yes ○ No
(Packaging, package insert, prescription)

Epidemiological History

CRF - Epidemiological History

Did the patient travel recently (in the last 30 days)?

○ Yes ○ No

To which State:

○ Acre ○ Alagoas ○ Amapá
○ Amazonas ○ Bahia
○ Ceará ○ Distrito Federal
○ Espírito Santo ○ Goiás
○ Maranhão ○ Mato Grosso
○ Mato Grosso do Sul ○ Minas Gerais
○ Pará ○ Paraíba ○ Paraná
○ Pernambuco ○ Piauí
○ Rio de Janeiro ○ Rio Grande do Norte
○ Rio Grande do Sul ○ Rondônia
○ Roraima ○ Santa Catarina
○ São Paulo ○ Sergipe
○ Tocantins

City/Town:

_____

Day of return:

○ Not known ○ 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

Month of return:

○ Not known ○ Jan
○ Feb ○ Mar ○ Apr
○ May ○ Jun ○ Jul
○ Aug ○ Sep ○ Oct
○ Nov ○ Dec

Year of return:

_____

Length of stay in the city/town:

_____

(in days)

Are there any cases of Dengue where you live/work?

○ Yes ○ No ○ Not known

Are there any cases of Zika where you live/work?

○ Yes ○ No ○ Not known

Are there any cases of Chikungunya where you live?

○ Yes ○ No ○ Not known

Are there any cases of Chikungunya where you work?	○ Yes ○ No ○ Not known
Do you live or work near wasteland?	○ Yes ○ No
History of Dengue	○ Yes ○ No ○ Not known
Month:	○ Not known ○ Jan ○ Feb ○ Mar ○ Apr ○ May ○ Jun ○ Jul ○ Aug ○ Sep ○ Oct ○ Nov ○ Dec
Year:	_____
History of Zika	○ Yes ○ No ○ Not known
Month:	○ Not known ○ Jan ○ Feb ○ Mar ○ Apr ○ May ○ Jun ○ Jul ○ Aug ○ Sep ○ Oct ○ Nov ○ Dec
Year:	_____

Vaccination History

Have you been vaccinated against Yellow Fever (last 10 years)?	○ Yes ○ No ○ Not known
Year:	_____
Have you been vaccinated against Dengue?	○ Yes ○ No ○ Not known
Year:	_____

PREVIOUS MEDICAL HISTORY

CRF – Previous Medical History (Comorbidities)

Do you have any comorbidities?	○ Yes ○ No
Anemia:	○ Yes ○ No ○ Not known
Diabetes:	○ Yes ○ No ○ Not known
Systematic arterial hypertension:	○ Yes ○ No ○ Not known
Asthma:	○ Yes ○ No ○ Not known
Rhinitis:	○ Yes ○ No ○ Not known
Chronic obstructive pulmonary disease (COPD):	○ Yes ○ No ○ Not known
Coronary disease:	○ Yes ○ No ○ Not known
Kidney disease:	○ Yes ○ No ○ Not known
Please specify:	_____
Rheumatism:	○ Yes ○ No ○ Not known
Please specify:	_____
Vascular disease:	○ Yes ○ No ○ Not known
Please specify:	_____
Benign, malignant or nonspecific neoplasms:	○ Yes ○ No ○ Not known
Please specify:	_____
Liver Disease:	○ Yes ○ No ○ Not known
Please specify:	_____
HIV infection:	○ Yes ○ No ○ Not known
Other Relevant Comorbidities:	○ Yes ○ No
Which:	_____

CLINICAL EVALUATION

CRF – Clinical Evaluation

Scheduled visit nº: _____

Date of visit: _____

Participant ID: _____

Participant QR Code: _____

Vital Signs

Weight (kg): _____

Height (cm): _____

BMI: _____

Blood pressure (mmHg):

Systolic: _____

Diastolic: _____

Heart rate (bpm): _____

Respiratory frequency (rpm): _____

Body temperature (ºC): _____

Physical exam

Diagnostic impression:

Prescription Drugs

Has medication been prescribed? ○ Yes ○ No

How many different medicines?

○ 1
○ 2
○ 3
○ 4
○ 5
○ 6
○ 7
○ 8
○ 9
○ 10

Medication 1:

Generic Name:

_____

Amount (mg/mL):

_____
(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 2:

Nome Genérico:

_____

Amount (mg/mL):

_____
(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 3:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 4:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 5:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 6:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 7:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 8:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 9:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

Prescription Drugs

Medication 10:

Generic Name:

_____

Amount (mg/mL):

_____

(Unit)

Dosage:

_____

Duration of Treatment (days):

_____

Therapeutic Indication:

_____

RHEUMATOLOGICAL CONSULTATION

CRF - Rheumatological Consultation

Date: _____

Diagnostic hypothesis: ○ Dengue ○ Zika ○ Chikungunya

How long has patient had musculoskeletal manifestations? _____

Prior rheumatological condition: ○ No ○ Yes

Which? _____

	0	1	2	3	4	5	6	7	8	9	10
Pain:	○	○	○	○	○	○	○	○	○	○	○
Fatigue:	○	○	○	○	○	○	○	○	○	○	○
Global Health Evaluation:	○	○	○	○	○	○	○	○	○	○	○
Disease Activity (Patient):	○	○	○	○	○	○	○	○	○	○	○
Disease Activity (Doctor):	○	○	○	○	○	○	○	○	○	○	○

Pain: _____

Edema: _____

According to Homunculus, considering 44 total joints:

Number of Painful Joints - NPJ: _____

Number of Swollen Joints - NSJ: _____

Bursitis: ○ Yes ○ No

Region: _____

Tenosynovitis: ○ Yes ○ No

Region: _____

Enthesitis: ○ Yes ○ No

Region:

_____

Carpal Tunnel Syndrome: ○ Yes ○ No

Region:

_____

Other: ○ Yes ○ No

Region:

_____

Rheumatoid Arthritis Disease Activity Index:

_____

	None	Mild	Moderate	Severe
Neck:	○	○	○	○
Back:	○	○	○	○

Left Side

	None	Mild	Moderate	Severe
Shoulder:				
Elbow:	○	○	○	○
Wrist:	○	○	○	○
Hand:	○	○	○	○
Hip:	○	○	○	○
Knee:	○	○	○	○
Ankle:	○	○	○	○
Foot:	○	○	○	○

Right Side

	None	Mild	Moderate	Severe
Shoulder:	○	○	○	○
Elbow:	○	○	○	○
Wrist:	○	○	○	○
Hand:	○	○	○	○
Hip:	○	○	○	○
Knee:	○	○	○	○
Ankle:	○	○	○	○
Foot:	○	○	○	○

DAS-28 Score for Rheumatoid Arthritis:
Use only 28 joints (shoulders, elbows, wrists, metacarpophalangeal joints, proximal interphalangeal joints, and knees, bilaterally)

ESR: _____ (mm/hr)

DAS-28ESR: _____

Remission

Low

Moderate

High

Clinical Disease Activity Index - CDAI

CDAI: _____

Remission

Low

Moderate

High

Clinical Disease Activity Index - SDAI

C-reactive protein: _____ (mg/dL)

SDAI: _____

Remission

Low

Moderate

High

Patient with disease activity classified as: ◯ Remission ◯ Low ◯ Moderate ◯ High

SELF-APPLICABLE QUESTIONNAIRES

Scheduled visit nº: _____

Date: _____

Phase of study:
- ◯ Acute Phase
- ◯ Chronic Phase
- ◯ Sub-acute Stage

Numerical scales to be filled in by patient

	0	1	2	3	4	5	6	7	8	9	10
Pain: How much joint pain have you had in the last week? 0- No pain 10- Worst pain possible	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Fatigue: How much abnormal tiredness has been a problem for you in the last week? 0- Fatigue is not a problem 10- Fatigue is a big problem	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Disease activity today: Considering the pain and swelling of your articulations, how would you describe the activity of your rheumatic condition today? 0- No activity 10- Extremely active	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Disease activity in the last 6 months: Considering the pain and swelling of your articulations, how would you describe the the activity of your rheumatic condition in the last six months? 0- No activity 10- Extremely active	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
General Health: Considering all the manners in which your health and disease affect you right now, how do you feel? 0- Very well 10- Very bad	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Morning Stiffness: Were your joints stiff when you woke up today?	◯ No ◯ < 30min ◯ > 30min and < 1 h ◯ > 1 and < 2 hrs ◯ > 2 and < 4 hrs ◯ > 4 hrs ◯ All day

HAQ (Health Assessment Questionnaire

In this section, we would like to know how your illness affects your ability to perform your daily activities.

Please mark the answer that best describes your ability to perform day to day activities. IN THE LAST WEEK:

	No difficulty	Some difficulty	A lot of difficulty	Unable to do them
1. Dressing, including tying shoelaces and buttoning clothes	◯	◯	◯	◯
2. Washing your hair	◯	◯	◯	◯
3. Getting up from a chair without help	◯	◯	◯	◯
4. Lying down or getting out of bed	◯	◯	◯	◯
5. Cutting meat	◯	◯	◯	◯
6. Raising a mug or glass to your mouth	◯	◯	◯	◯
7. Opening a carton of milk	◯	◯	◯	◯
8. Walking outside on a flat surface	◯	◯	◯	◯
9. Climb 5 steps	◯	◯	◯	◯
10. Washing and drying your body	◯	◯	◯	◯
11. Having a bath / shower	◯	◯	◯	◯
12. Sitting on or getting up from the toilet	◯	◯	◯	◯
13. Reaching and getting a 2 kg object (for example, a sack of potatoes) from above your head	◯	◯	◯	◯
14. Bend over or crouch to pick up clothes from the floor	◯	◯	◯	◯
15. Open a car door	◯	◯	◯	◯

16. Open pots that have previously been opened	○	○	○	○
17. Open and close taps	○	○	○	○
18. Go to the bank and go shopping	○	○	○	○
19. Get in and out of a car	○	○	○	○
20. Do housework (for example, sweeping and working in the garden)	○	○	○	○

SF-12 (Short Form-12)

In this section, this questionnaire asks some questions about the activities you perform during your day. Answer each question by marking the answer as indicated. If you are unsure how to respond, please try to answer as best you can.

1. In general would you say your health is:

○ Excellent ○ Very good ○ Good ○ Bad ○ Very bad

The following items are about activities you could currently do during an ordinary day. Because of your health, would you have difficulty doing these activities? In this case, how much difficulty?

2. Moderate activities such as moving a table, vacuuming, playing ball, sweeping the house:

○ My disease makes it very difficult ○ My disease makes it a little difficult ○ It doesn't make it difficult at all

3. Climb various flights of stairs

○ My disease makes it very difficult ○ My disease makes it a little difficult ○ It doesn't make it difficult at all

During the past four weeks, have you had any of the following problems with your work or regular daily activity as a result of your physical health?

4. Did you perform fewer tasks than you would have liked? ○ Yes ○ No

5. Have you been limited in your type of work or in other activities? ○ Yes ○ No

During the past four weeks, have you had any of the following problems with your work or regular daily activity as a result of an emotional problem (such as feeling depressed or anxious)?

6. Did you perform fewer tasks than you would have liked? ○ Yes ○ No

7. Haven't worked or done any of the activities as carefully as you usually do? ○ Yes ○ No

8. During the past four weeks, how much has the pain interfered with your normal work (including both work, away from home and indoors)?

○ Not at all ○ A little ○ Moderately ○ A lot ○ Extremely

	All the time	Very frequently	Frequently	Sometimes	Not often	Never
9. How often do you feel calm or relaxed?	○	○	○	○	○	○
10. How often do you feel energetic?	○	○	○	○	○	○
11. How often do you feel depressed or down?	○	○	○	○	○	○

12. During the past four weeks, how much of your time has your physical health or your emotional problems interfered with your social activities such as visiting friends, relatives, etc.)?

○ The whole time ○ Most of the time
○ Some of the time
○ A little of the time
○ None of the time

Hospital Anxiety and Depression Questionnaire (HAD a/d)

This questionnaire will help your doctor know how you are feeling. Read all the sentences. Mark with an X how you were feeling LAST WEEK. No need to think too much about each question. In this questionnaire, spontaneous answers have more value than those that are thought too much about. Mark only one answer for each question.

1. I feel tense or stressed:

○ Very often ○ Often ○ Sometimes ○ Never

2. I still like the same things as before:

○ Yes, just as before ○ Not as much as before ○ Just a little ○ I don't feel pleasure anymore

3. I feel a kind of fear, as if something bad is going to happen:

○ Yes, and quite strongly ○ Yes, but not very strongly ○ A little, but I'm not worried
○ Not at all

4. I laugh and have fun when I see some funny things:

○ Just as before ○ Nowadays, a bit like before ○ Nowadays, a lot less
○ I don't laugh anymore

5. I have a head full of worries:

○ Very often ○ Often ○ Sometimes ○ Rarely

6. I feel happy:

○ Never ○ Rarely ○ Often ○ Very often

7. I can sit at ease and feel relaxed:

○ Yes, almost always ○ Often ○ Not often ○ Never

8. I am slow to think and do things:

○ Almost always ○ Very often ○ Sometimes ○ Never

9. I have a strong feeling of fear, like a cold feeling in my belly or a tightness in my stomach:

○ Never ○ Sometimes ○ Very often ○ Almost always

10. I have lost interest in taking care of my appearance:

○ Completely ○ I'm not taking care of myself anymore like I should ○ Maybe not as much as before
○ I take care of myself the same way as before

11. I feel restless, as if I can't stand still wherever I go:

○ Yes, a lot ○ Quite a lot ○ A little ○ I don’t feel that way

12. I’m looking forward to the good things yet to come:

○ Just like before ○ A little less than before ○ A lot less than before ○ Almost never

13. I suddenly have a feeling of panic:

○ Almost the whole time ○ Often ○ Sometimes ○ I don’t suffer from that

14. When I watch a good TV show, radio show or when I read something I can enjoy it:

○ Almost always ○ Often ○ Not very often ○ Almost never

WPAI (Work Productivity and Activity Impairment)

The questions below ask about the effect of your health problems on your ability to work and perform activities regularly.
By health problems we are referring to any physical or emotional problem or symptom.

1) Are you currently employed (paid work)? ○ Yes ○ No

The next questions refer to the last seven days, not including today.

2) During the past seven days, how many hours did you have to stop working because of your health problems?

_____

(Include hours not worked when you were sick, late, left early, etc., because of your health or digestive problems. Do not include the time you missed in order to participate in this study.)

3) During the past seven days, how many hours did you stop working for any other reason, such as vacations, holidays, free time to participate in this study?

_____

4) During the last seven days, how many hours did you work?

_____

(If "0", write "0")

5) During the past seven days, how much did your health problems affect your productivity while you were working? Think about the days you were limited in the amount or type of work you could do, the days you did less than you would have liked to do, or the days you were less careful than usual in your work.
If health problems have affected your work only slightly, choose a low number. Choose a high number if health problems have affected your work a lot.

0- Health problems did NOT affect my work
10- Health problems completely prevented me from working

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6) During the past seven days, how much have your health problems affected your ability to do your regular daily activities, (other than work at your job)? By regular activities we mean common activities you do at home, shopping, childcare, working out, study etc. Think about the times you were limited in the amount or type of activities you could do and the times you did less than you would have liked. If health problems have affected your activities only slightly, choose a low number. Choose a high number if health problems have affected your activities a lot.

0- Health problems did NOT affect my regular daily activities
10- Health problems completely prevented me from doing regular daily activities

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

RADAI (Rheumatoid Arthritis Disease Activity Index)

	None	Mild	Moderate	Severe
Neck	○	○	○	○
Back	○	○	○	○

Left side

	None	Mild	Moderate	Severe
Shoulder	○	○	○	○
Elbow	○	○	○	○
Wrist	○	○	○	○
Hand	○	○	○	○
Hip	○	○	○	○
Knee	○	○	○	○
Ankle	○	○	○	○
Foot	○	○	○	○

Right side

	None	Mild	Moderate	Severe
Shoulder	○	○	○	○
Elbow	○	○	○	○
Wrist	○	○	○	○
Hand	○	○	○	○
Hip	○	○	○	○
Knee	○	○	○	○
Ankle	○	○	○	○
Foot	○	○	○	○

Neuropathic Pain Questionnaire - DN-4

Does your pain have one or more of the following characteristics?

	Yes	No
1. Burning:	○	○
2. Cold Feeling:	○	○
3. Electric shock:	○	○

Is 1 or more of the following symptoms present in the areas where you feel pain?

	Yes	No
4. Tingling:	○	○
5. Pinpricks:	○	○
6. Numbness:	○	○
7. Itching:	○	○

Questions completed via medical examination

Pain is located in an area where physical examination may reveal one or more of the following characteristics:		
	Yes	No
8. Hypoesthesia when touched:	○	○
9. Hypoesthesia when stung by a bee	○	○

In the painful area the pain may be caused or increased by:		
	Yes	No
10. Brushing:	○	○

Check which statement best describes your state of health TODAY

Descriptive System EQ-5D-3L

Mobility:	○ I have no problem walking ○ I have some problems walking ○ I am bedridden
Personal care:	○ I have no problems with my personal care ○ I have some problems washing and dressing ○ I am incapable
Usual Activities:	○ I have no problem performing my usual activities ○ I have some problems performing my usual activities ○ I am unable to perform my usual activities (e.g. work, study, housework, family or leisure activities)
Pain/ Feeling unwell:	○ I have no pain or discomfort ○ I have moderate pain or discomfort ○ I have extreme pain or discomfort
Anxiety/Depression:	○ I'm not anxious or depressed ○ I am moderately anxious or depressed ○ I am extremely anxious or depressed
Visual Analog Scale (VAS):	0 50 100 *(Place a mark on the scale above)*

IMAGING EXAMS

Scheduled visit nº: _____

PID Number: _____

Date: _____

Was an imaging exam performed? ○ Yes ○ No

Motive: _____

Type of exam:
○ Ultrasound
○ X-ray
○ Tomography
○ MR scan
○ Other

Which? _____

Date of test: _____

Region/Area _____

Result: ○ Normal ○ Abormal ○ Not known

Description of the abnormality

Type: _____

Location: _____

Size: _____

Attachments

Report atttached: ○ Yes ○ No

Attach image:

Images uploaded: ○ Yes ○ No

Attach image:

LABORATORY RESULTS

PID Number: _____

Scheduled visit nº: _____

Date: _____

BLOOD

Blood test done? ○ Yes ○ No

Motive: _____

Date blood test done: _____

Time blood test done: _____
(HH:MM)

Blood count done? ○ Yes ○ No

Motive: _____

Date blood count done: _____

Hemoglobin ○ Not known /Error

Result: _____

Unit of measurement: ○ g/L ○ g/dL ○ Other

Other: _____

Hematocrit ○ Not known /Error

Result: _____

Unit of measurement: ○ % ○ Other

Other: _____

Red blood cells	○ Not known /Error
Result:	_____
Unit of measurement:	○ Millions/mm³ ○ Millions/µL ○ Other
Other:	_____
MCV	○ Not known /Error
Result:	_____
Unit of measurement:	○ fL ○ µm³ ○ u3 ○ Other
Other:	_____
MCH	○ Not done ○ Not known/Error
Result:	_____
Unit of measurement:	○ pg ○ Other
Other:	_____
MCHC	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ % ○ g/dL ○ Other
Other:	_____
White blood cell count	○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ x10³/µl ○ Other
Other:	_____
Segmented nucleus	○ Not known /Error

Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Band cell	○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Neutrophils	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Metamelocytes	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Lymphocytes	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Monocytes	○ Not done ○ Not known /Error
Result:	_____

Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Eosinophils	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Basophils	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ % ○ Other
Other:	_____
Platelet count	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm³ ○ mil/mm³ ○ Other
Other:	_____
ERS	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mm/h ○ Other
Other:	_____

Biochemistry

Was biochemistry performed?	○ Yes ○ No
Date performed	_____
Motive:	_____
AST	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ U/L ○ IU/L ○ Other
Other:	_____
ALT	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ U/L ○ IU/L ○ Other
Other:	_____
Glucose	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mg/dL ○ Other
Other:	_____
Urea	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mg/dL ○ Other
Other:	_____
Creatinine	○ Not done ○ Not known /Error
Result:	_____

Unit of measurement:	○ mg/dL ○ Other
Other:	_____
C-reactive protein	○ Not done ○ Not known /Error
Result:	_____
Unit of measurement:	○ mg/dL ○ Other
Other:	_____
Were other tests done?	○ Yes ○ No
How many?	○ 1 ○ 2 ○ 3 ○ 4
Test:	_____
Result:	_____
Unit of measurement:	_____
Test:	_____
Result:	_____
Unit of measurement:	_____
Test:	_____
Result:	_____
Unit of measurement:	_____
Test:	_____
Result:	_____
Unit of measurement:	_____

Serological test: DPP Dengue/Zika/Chikungunya

Was a serological test performed?	○ Yes ○ No
Date of test:	_____
Motive:	_____
Dengue	
Dengue IgG	○ IgG reactive ○ IgG non-reactive ○ IgG indeterminado
Dengue IgM	○ IgM reactive ○ IgM non-reactive ○ IgM undetermined
Zika	
Zika IgG	○ IgG reactive ○ IgG non-reactive ○ IgG undetermined
Zika IgM	○ IgM reactive ○ IgM non-reactive ○ IgM undetermined
Chikungunya	
Chikungunya IgG	○ IgG reactive ○ IgG non-reactive ○ IgG undetermined
Chikungunya IgM	○ IgM reactive ○ IgM non-reactive ○ IgM undetermined

Molecular test: ZDC Dengue/Zika/Chikungunya - SANGUE

Molecular test done?	○ Yes ○ No
Date of test	_____
Motive:	_____
Dengue	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____
Zika	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____

Chikungunya	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____

URINE

Was a urine sample taken?	○ Yes ○ No
Date taken:	_____
Time taken:	_____ (HH:MM)
Motive:	_____

Molecular test: ZDC Dengue/Zika/Chikungunya - URINE

Molecular test performed?	○ Yes ○ No
Date test performed:	_____
Motive:	_____
Dengue	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____
Zika	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____
Chikungunya	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____

SALIVA

Was a saliva sample taken? ○ Yes ○ No

Date taken

_____

Time taken

_____
(HH:MM)

Motive:

_____

Molecular test: ZDC Dengue/Zika/Chikungunya - SALIVA

Molecular test performed? ○ Yes ○ No

Date test performed

_____

Motive:

_____

Dengue ○ Detected ○ Not detected ○ Inconclusive

Ct:

_____

Zika ○ Detected ○ Not detected ○ Inconclusive

Ct:

_____

Chikungunya ○ Detected ○ Not detected ○ Inconclusive

Ct:

_____

SYNOVIAL FLUID - Non-mandatory sampling

Was a synovial fluid sample taken? ○ Yes ○ No

Date taken

_____

Time taken

_____
(HH:MM)

Motive:

_____

Molecular Test: ZDC Zika/Dengue/Chikungunya - SYNOVIAL FLUID

Molecular test done?	○ Yes ○ No
Date of test	_____
Motive:	_____
Dengue	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____
Zika	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____
Chikungunya	○ Detected ○ Not detected ○ Inconclusive
Ct:	_____

Additional comments:

Notes/ Comments	_____

ADVERSE REACTIONS TO MEDICATIONS

Description of what occurred:

_____

Day when occurred:

- ◯ 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
- ◯ Not known

Month when occurred:

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December
- ◯ Not known

Year when occurred:

_____

When did it end?

Day ended:

- ◯ 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
- ◯ Not known

Month ended:

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December
- ◯ Not known

Year ended:

_____

Did the symptoms last for less than 24 hours?

◯ Yes ◯ No

(Complete only if the symptoms lasted for less than 24 hours)

What time did it begin?

_____

What time did it end?

_____

Total time in minutes: _____

Amount of suspected medications: 1 2 3

Suspected medication(s): ○ ○ ○ _____

Suspected medication(s): _____

Suspected medication(s): _____

What action was taken in response to the adverse event?

○ Amount has not changed
○ Amount increased
○ Amount decreased
○ Medication temporarily discontinued
○ Medication suspended
○ Additional treatment (use of other medications, hospitalization)
○ Other
○ Not reported

Which? _____

	Yes	No	Not known
Has the medication been reintroduced?	○	○	○
Did the participant have a similar reaction with the same or similar medication?	○	○	○
Did the participant require hospitalization or prolonged hospitalization as a result of the event?	○	○	○ Not reported
Did he event cause significant or permanent disability or dysfunction?	○	○	○ Not reported

What significant permanent disability or dysfunction? _____

What was the outcome of the adverse reaction?

○ Fatal ○ No recovery / Not solved
○ Recovered / Resolved with side effects
○ In recovery ○ Recovered / Solved ○ Not known

SYMPTOMS

Type of symptom:	◯ Fever ◯ Headache ◯ Fatigue ◯ Pallor skin / mucous membranes ◯ Jaundice ◯ Conjunctival hyperemia ◯ Visual turbidity ◯ Vomiting ◯ Diarrhea ◯ Abdominal pain ◯ Paraesthesia ◯ Dysesthesia ◯ Arthralgia ◯ Edema ◯ Myalgia ◯ Backache ◯ Itching ◯ Cutaneous Rash ◯ Skin lesions ◯ Depression ◯ Insomnia ◯ Changes to memory ◯ Change in libido ◯ Impotency ◯ Other
Which:	_____
Date began:	_____
Has this continued until the end of the follow up?	◯ Yes ◯ No
Date ended:	_____

REPLICK - PRE-SCREENING

Pre-screening

Does the participant meet all eligibility criteria? ○ Yes ○ No

Was the consent process performed? ○ Yes ○ No

Justify: _____

Date consent obtained: _____

Inclusion criteria

	Yes	No
Is the participant 18 or over?	○	○
Does the participant have a fever (body temperature over or equal to 37.8 ° C) And arthralgia of recent onset (less than or equal to 10 days)	○	○
Does the participant have arthralgia after fever (equal to or less than 7 days), and is suspected of having an arbovirus (Dengue, Chikungunya, Zika)?	○	○

Exclusion Criteria

	Yes	No
Is Participant unavailable for follow-up visits at the research center?	○	○
Does participant evidently have a fever with supposed nonviral origin (cellulitis and abscess)?	○	○
Participant with severe mental disorder that makes it impossible to understand and complete the protocol or does not allow information gathering due to communication disorders, lack of fluency in Portuguese or another language understood by the doctor / assistant / nurse	○	○

Was participant excluded for another reason not specified above?

○ Yes ○ No ○ Não se aplica

Which:

_____

Participant PID:

_____