NAME

DOB

PATIENT ID NUMBER: [ ][ ][ ][ ][ ][ ][ ][ ]

JOINTS (FOLLOW-UP, NURSE LED)

Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]

Currently experiencing any of the following?

Abnormal appearance and/or movement of head and/or neck ☐NO ☐YES

Dental symptoms ☐NO ☐YES

Low back pain/ache ☐NO ☐YES

Muscle and/or Joint pain/ache ☐NO ☐YES

Pain with chewing ☐NO ☐YES

Rib or costochondral pain (point to sternum/costochondral area when asking) ☐NO ☐YES

Other (e.g. redness, swelling, stiffness) ☐NO ☐YES☐N/A If YES, specify _____

Which joints are involved in current symptoms?☐Check here if none and all items below are NO

Shoulder	☐No	☐Right	☐Left	☐Both	Note _____
Elbow	☐No	☐Right	☐Left	☐Both	Note _____
Wrist	☐No	☐Right	☐Left	☐Both	Note _____
Knuckles(MPC)	☐No	☐Right	☐Left	☐Both	Note _____
Proximal interphalangeal (PIP)	☐No	☐Right	☐Left	☐Both	Note _____
Distal interphalangeal (DIP)	☐No	☐Right	☐Left	☐Both	Note _____
Hip	☐No	☐Right	☐Left	☐Both	Note _____
Knee	☐No	☐Right	☐Left	☐Both	Note _____
Ankle	☐No	☐Right	☐Left	☐Both	Note _____
Heel	☐No	☐Right	☐Left	☐Both	Note _____
Jaw (TMJ)	☐No	☐Right	☐Left	☐Both	Note _____
Neck/spine	☐No	☐Right	☐Left	☐Both	Note _____
Ribs	☐No	☐Right	☐Left	☐Both	Note _____
Costochondral	☐No	☐Right	☐Left	☐Both	Note _____
Other, specify _____	☐No	☐Right	☐Left	☐Both	Note _____

Did the joint symptoms start before, during, or after previous visit?
☐Before ☐During ☐After previous visit

Are symptoms worse in the morning or end of the day (check one) ☐Morning ☐End of day ☐No difference

Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change

If eye symptoms also exist, did the joint symptoms start before, at the same time, or after the eye symptoms started
☐Before eye symptoms started ☐Stated at same time ☐After eye symptoms started

EYES –((FOLLOW-UP, NURSE LED))

Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]

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Clinical picture this visit	
Blurry vision	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Dry eye	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Eye burning	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Eye foreign body sensation	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Eye pain	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Flashes of light	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Floaters	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Full loss of vision	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Itchy eye	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Light sensitivity	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Red eye	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Watery eye (tearing without crying)	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Other, specify_____	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____
Other, specify_____	☐No ☐Right eye ☐Left eye ☐Both eyes Note:_____

Did first eye symptoms start before, during or after previous visit ☐Before ☐During ☐After

Are the main symptoms getting better or worse from when it first started ☐Better ☐Worse ☐No change

Did you receive any eye drops for the symptoms since last visit ☐YES ☐NO

If YES, how did the symptoms change after starting the drops ☐No change ☐Got better ☐Got worse

Did you receive any oral steroids for the symptoms since last better ☐YES ☐NO

If YES, how did the symptoms change after starting the oral steroids ☐No change ☐Got better ☐Got worse

Notes on relevant ocular history

_____

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HEADACHE (FOLLOW-UP, NURSE LED) Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Site of pain	☐Unilateral ☐ Bilateral Site, specify_
Intensity of pain	☐mild- does not affect daily activities ☐moderate- able to perform daily activities on medication ☐severe- unable to perform day-to- day activities ☐very severe- needing bed rest
Frequency of episodes	☐Everyday ☐>3/week ☐>3/month ☐ Rare Others, specify _____
Duration of episode	☐< 1hour ☐1-4 hours ☐ 4- 72 hours ☐ ceases on medication Others, specify _____
Associated symptoms	☐Photophobia ☐Lacrimation ☐Retro orbital pain ☐Nausea/vomiting ☐Stiff neck Others , specify _____
Medication	☐on regular medication ☐on SOS basis specify medication _____
Did first eye symptoms start before, during or after previous visit ☐Before ☐During ☐After Are the main symptoms getting better or worse from when it first started ☐Better ☐Worse ☐No change	

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EARS –(FOLLOW-UP, NURSE LED)	
Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Cannot hear (complete loss)	☐No ☐Right only ☐Left only ☐Both Note _____
Hearing loss (incomplete loss)	☐No ☐Right only ☐Left only ☐Both Note _____
Ringing/sound in ear	☐No ☐Right only ☐Left only ☐Both Note _____
Aural fullness (feels like water in ears)	☐No ☐Right only ☐Left only ☐Both Note _____
Vertigo/ Postural giddiness	☐No ☐Right only ☐Left only ☐Both Note _____
Other, specify_____	☐No ☐Right only ☐Left only ☐Both Note _____

Did the first ear symptoms start before, during, or after previous visit?
☐Before ☐During (In ETU) ☐After discharge

If eye symptoms also exist, did the ear symptoms start before, at the same time, or after the eye symptoms started
☐Before eye symptoms started ☐Stated at same time ☐After eye symptoms started

Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change

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NEUROLOGY(FOLLOW-UP, NURSE LED) Complete also NEUROLOGY (Examination) Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Seizures/ Fits	☐NO ☐YES If YES, Associated symptoms: ☐ Unconsciousness ☐Sudden rapid eye movements☐fall/injury☐post seizure confusion
Changes in memory or thinking	☐NO ☐YES If YES, describe_____
Irritability	☐NO ☐YES
Changes in ability to smell or taste	☐NO ☐YES If YES, describe _____
Numbness or tingling of face	☐NO ☐YES If YES, ☐RIGHT ☐LEFT ☐BOTH
Change in sound of voice	☐NO ☐YES If YES, describe _____
Dizziness or vertigo (room spinning)	☐NO ☐YES If YES, describe _____
Weakness or heaviness of limbs	☐NO ☐YES If YES, ☐RIGHT ☐LEFT ☐BOTH
Trouble buttoning clothes or putting on jewellery	☐NO ☐YES If YES, describe _____
Cramps or twitching of muscles	☐NO ☐YES If YES, describe _____
Atrophy (or shrinking) of muscles	☐NO ☐YES If YES, describe _____
Sharp or shooting pains	☐NO ☐YES If YES, describe _____
Tremors	☐NO ☐YES If YES, ☐Coarse ☐Fine
Movement problems	☐NO ☐YES
Feeling of numbness or coldness	☐NO ☐YES If YES, describe _____
Hiccups	☐NO ☐YES
Gait	☐Normal ☐Abnormal
Did the first neurological symptoms start before, during, or after previous visit? ☐Before ☐During (In ETU) ☐After	

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CARDIAC& RESPIRATORY (FOLLOW-UP, NURSE LED) Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Chest Pain	☐NO ☐YES If YES, Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change Site of pain : ☐ Retro sternal ☐Anterior chest☐Lateral sides of chest wall ☐ epigastric ☐Unilateral ☐Localized, specify _____ Onset : ☐ Sudden ☐Insidious/ subtle Type: ☐ Stabbing ☐ Pressure/ tightness☐Burning ☐Pleuritic Radiation: ☐Neck/jaw/left arm ☐ Back ☐Dermatomal Associated with: ☐ Dyspnea (difficulty breathing) ☐ Palpitations ☐ Cough ☐ Excessive sweating ☐ Wheeze ☐Vesicular ash Aggravating factors: ☐ Stress ☐Deep inspiration ☐Localized pressure, specify _____ Relieving factors: ☐Angina medication(NTG) ☐Antacids/ food
Palpitations	☐NO ☐YES If YES, Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change Associated factors: ☐ Dyspnea ☐ Chest pain ☐ Excessive sweating ☐ Stress/ anxiety
Difficulty Breathing	☐NO ☐YES If YES, Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change List: ☐On exertion ☐With daily activities ☐Orthopnea(on lying supine) ☐Paroxysmal Nocturnal Dyspnea (3-4 hours after sleep) ☐ Sudden onset ☐Others,
Swollen Ankles	☐NO ☐YES Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change

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Cough	☐NO ☐YES If YES, Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change ☐Productive ☐non-productive} If Productive, drop down menu with the following ☐White ☐Green ☐ Brown ☐ Spotted with blood ☐ Frank blood ☐ other} If OTHER describe _____
Coryzal Symptoms (Sneezing/runny nose)	☐NO ☐YES Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change
Dizziness	☐NO ☐YES If Yes,: Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved Worse ☐ No change ☐ ☐ Dyspnea ☐ Chest pain ☐Palpitations☐Excessive sweating
Other	☐NO ☐YES If YES, describe _____ Are symptoms getting better or worse from when they first started ☐ Resolved ☐ Improved ☐ Worse ☐ No change

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GASTROINTESTINAL (FOLLOW-UP, NURSE LED)

Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]

Abdominal pain?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change Do you know the cause of this abdominal pain?
Symptoms of Nausea	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Vomitting	☐NO ☐YES If YES, Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change ☐ Normal food contents ☐ bile ☐ dark/coffee-ground ☐ fresh blood ☐ other If OTHER_____
Difficulty swallowing	☐NO ☐YES If YES, Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change ☐ solids ☐ liquids ☐ both)

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Pain when swallowing?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Heartburn/indigestion?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Yellowing of the skin/eyes?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Itching of the skin?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Cconstipation?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Tenesmus (feeling of incomplete evacuation)?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐

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	weeks ☐ months Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change
Ddiarrhoea / loose stools	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Change in the colour of stool/any mucus in bowel motion	☐NO ☐YES If YES, Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change ☐ dark/black stool ☐ pale stool ☐ fresh blood with stool)
Mucus in stool	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Weight loss (unintentional)	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change ☐N/A
Loss of appetite / poor intake	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months

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	Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Excess hunger / voracious appetite	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change

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RENAL/UROLOGY (FOLLOW-UP, NURSE LED) Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Pain when passing urine	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After If started after discharge, how long before now [___][___] ☐days ☐ weeks ☐ months Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Increased frequency of passing urine	☐NO ☐YES If YES, during ☐DAYTIME ☐NIGHTTIME ☐ BOTH Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change
Blood in your urine?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved☐Worse ☐No change
Incontinence of urine?	☐NO ☐YES If YES,: Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change Timing: ☐ when laughing ☐coughing ☐ straining ☐.sudden urgency ☐ other) If OTHER describe _____
Urinary retention?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Difficulty starting urination (Males)	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After

	Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Poor urine stream/flow	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Dribbling after urination? (Males)	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Swelling of the ankles?	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change

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FEMALE REPRODUCTIVE (FOLLOW-UP, NURSE LED) Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]	
Pelvic pain/lower abdominal pain	☐NO ☐YES If YES, describe_____ Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Increased bleeding during menstruation	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Amenorrhoea (no periods for 6 months and not pregnant, peri-/post-menopausal or underweight)	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Vaginal bleeding between periods	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Vaginal bleeding after sexual intercourse	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Pain during sexual intercourse	☐NO ☐YES If YES, drop down (superficial, deep) Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Change in vaginal discharge	☐NO ☐YES If YES, describe (inc amount, colour, smell, associated symptoms)

	_____ Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Have you tried to conceive a baby since the Ebola infection? (women)	☐NO ☐YES If yes, have you become pregnant? ☐NO ☐YES If yes, have you had any problems during pregnancy? ☐NO ☐YES

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MALE REPRODUCTIVE (FOLLOW-UP, NURSE LED)

Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]

Pain in scrotum	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Swelling in scrotum	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Discharge from end of penis	☐NO ☐YES If YES, describe _____ Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Difficulty getting/maintaining an erection	☐NO ☐YES Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change
Premature/delayed ejaculation	☐NO ☐PREMATURE ☐DELAYED Did the symptom start before, during, or after previous visit to the Ebola Survivors Clinic? ☐Before ☐During ☐After Are symptoms getting better or worse from when they first started ☐Resolved ☐Improved ☐Worse ☐No change

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PSYCHIATRY (FOLLOW-UP, NURSE LED)

Name of Nurse _____ Date of completion [__][_ _]/[_ _][_ _]/[__][_][__][__]]

PSYCHIATRY ☐Check here if Psychiatric is normal and all items below are NO

Difficulty sleeping	☐NO ☐YES If YES ☐Before ☐During (In Ebola survivors clinic) ☐After discharge Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change
Hallucinations	☐NO ☐YES If YES ☐Before ☐During (In Ebola survivors clinic) ☐After discharge Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change
Depression or excessive crying	☐NO ☐YES If YES ☐Before ☐During (In Ebola survivors clinic) ☐After discharge Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change
Anxiety	☐NO ☐YES If YES ☐Before ☐During (In Ebola survivors clinic) ☐After discharge Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change
Feeling scared/ frightened/ new phobias	☐NO ☐YES If YES ☐Before ☐During (In Ebola survivors clinic) ☐After discharge Are symptoms getting better or worse from when they first started ☐Better ☐Worse ☐No change