Participant ID Number

Daily Symptom Diary

(Optional)

Please keep this in a safe place.
Please complete it if you get an infection
while taking part in the
Immune Defence study

Please enter your **initials, and postcode** so we know who has completed the diary.

Please enter your initials here	
Please enter your postcode	

Thank you for taking part in the Immune Defence study

Getting an infection

It may be possible that you catch an infection whilst taking part in the study and we would like to get some more information about how you feel if you are unwell. *(By infection we mean coughs, colds, sore throat, sinus infections, ear infections and flu. This also includes COVID-19).* This symptom diary will collect this information.

Completing the diary is optional and it is up to you to decide whether you complete it or not. It won't take too long to complete and it will really help us to understand more about the symptoms you have while you have an infection.

If you are happy to complete the diary:

Please enter your **initials and postcode on the front of the diary** so we know who has completed the diary.

At the start of your illness
If you get an infection, please start completing the diary on the first day of your illness.

During your illness:
Please record your symptoms every day based on the previous 24 hours. Please keep recording them until you are better (or for 28 days). It won't take long, probably a couple of minutes each day.

When you are better (or after 28 days):
Please complete the final questions and post your diary back to the study team in the Freepost envelope.

If you do not want to complete the diary:

This is not a problem at all and has no impact on you taking part in the Immune Defence Study. Please continue with the study as instructed by the Immune Defence website.

Optional test for viruses

If you think you have Covid-19:

If you think you may have COVID-19 during the study please visit the www.gov.uk website and follow the current advice about getting tested. You can find out more about getting a test here: https://www.gov.uk/get-coronavirus-test

If you have any questions about completing the diary:

If you have any questions about completing the diary or taking part in the Immune Defence Study, please email the research team on <<email address>>

Please note that the study team **cannot give any advice** about your infections or your health. If you have any problems with your health, please contact your GP surgery or NHS111 as you normally would.

As soon as you become ill

Date you first became ill (dd/mm/yy): ____/_____/_____

(It can sometimes be hard to work out exactly when symptoms started. Just do your best to think of the first day you noticed a symptom).

We would like to know about any symptoms you had when you first became ill.

Abdominal pain	
Breathing difficulties	
Cough	
Coughing up phlegm	
Diarrhoea	
Difficulty swallowing	
Ear infection /ear ache	
Eye infection (conjunctivitis)	
Excessive sweating	
Feeling generally unwell	
Fever (high temperature)	
Headache	
Loss of small or taste	
Muscles aches	
Nausea and/or vomiting	
Pains in your chest	
Poor appetite	
Runny or blocked nose	
Sinusitis or facial pain	
Skin rashes	
Sore throat	
Sleep disturbance	
Tender or sore glands in the next	
Vomiting	
White spots on tonsils	

Please **write a number** in each box to indicate if you have had the symptom and how bad it was, using the following scale:

0 = normal/not had this symptom,

1 = very little problem,

2 = slight problem,

3 = moderately bad,

4 = bad,

5 = very bad,

6 = as bad as it could be

For example, if you think your fever has been: **as bad as it could be** you would put a **6** in the first box, but If you were **not affected** you would put a **0** in the box.

We would like to know about your general health
at the start of your illness (when you first became ill)

For each question below, please choose the statement that **best describes your health state today**. Please put a cross in ONE box for each question.

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

Week 1:

Please rate each symptom EVERY DAY based on the **previous 24 hours:**

0 = normal/not had this symptom, 1 = very little problem, 2 = slight problem, 3 = moderately bad, 4 = bad, 5 = very bad, 6 = as bad as it could be

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Abdominal pain							
Breathing difficulties							
Cough							
Coughing up phlegm							
Diarrhoea							
Difficulty swallowing							
Ear infection /ear ache							
Eye infection (conjunctivitis)							
Excessive sweating							
Feeling generally unwell							
Fever (high temperature)							
Headache							
Loss of small or taste							
Muscles aches							
Nausea and/or vomiting							
Pains in your chest							
Poor appetite							
Runny or blocked nose							
Sinusitis or facial pain							
Skin rashes							
Sore throat							
Sleep disturbance							
Tender or sore glands in the next							
Vomiting							
White spots on tonsils							

We would like to know about your general health **at the end of week 1**

For each question below, please choose the statement that **best describes your health state today**. Please put a cross in ONE box for each question.

MOBILITY
I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE
have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES
I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT
I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION
I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

Using your nasal spray *(VFD and saline only)*

How many times a day did you use your nasal spray ?

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Number of times a day							

Week 2:

Please rate each symptom EVERY DAY based on the **previous 24 hours:**

0 = normal/not had this symptom, 1 = very little problem, 2 = slight problem, 3 = moderately bad, 4 = bad, 5 = very bad, 6 = as bad as it could be

	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Abdominal pain							
Breathing difficulties							
Cough							
Coughing up phlegm							
Diarrhoea							
Difficulty swallowing							
Ear infection /ear ache							
Eye infection (conjunctivitis)							
Excessive sweating							
Feeling generally unwell							
Fever (high temperature)							
Headache							
Loss of small or taste							
Muscles aches							
Nausea and/or vomiting							
Pains in your chest							
Poor appetite							
Runny or blocked nose							
Sinusitis or facial pain							
Skin rashes							
Sore throat							
Sleep disturbance							
Tender or sore glands in the next							
Vomiting							
White spots on tonsils							

We would like to know about your general health **at the end of week 2**

For each question below, please choose the statement that **best describes your health state today**. Please put a cross in ONE box for each question.

MOBILITY
I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE
have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES
I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT
I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION
I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

Using your nasal spray *(VFD and saline only)*

How many times a day did you use your nasal spray ?

	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Number of times a day							

Week 3:

Please rate each symptom EVERY DAY based on the **previous 24 hours:**

0 = normal/not had this symptom, 1 = very little problem, 2 = slight problem, 3 = moderately bad, 4 = bad, 5 = very bad, 6 = as bad as it could be

	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
Abdominal pain							
Breathing difficulties							
Cough							
Coughing up phlegm							
Diarrhoea							
Difficulty swallowing							
Ear infection /ear ache							
Eye infection (conjunctivitis)							
Excessive sweating							
Feeling generally unwell							
Fever (high temperature)							
Headache							
Loss of small or taste							
Muscles aches							
Nausea and/or vomiting							
Pains in your chest							
Poor appetite							
Runny or blocked nose							
Sinusitis or facial pain							
Skin rashes							
Sore throat							
Sleep disturbance							
Tender or sore glands in the next							
Vomiting							
White spots on tonsils							

We would like to know about your general health
at the end of week 3

For each question below, please choose the statement that **best describes your health state today**. Please put a cross in ONE box for each question.

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

Week 4:

Please rate each symptom EVERY DAY based on the **previous 24 hours:**

0 = normal/not had this symptom, 1 = very little problem, 2 = slight problem, 3 = moderately bad, 4 = bad, 5 = very bad, 6 = as bad as it could be

	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28
Abdominal pain							
Breathing difficulties							
Cough							
Coughing up phlegm							
Diarrhoea							
Difficulty swallowing							
Ear infection /ear ache							
Eye infection (conjunctivitis)							
Excessive sweating							
Feeling generally unwell							
Fever (high temperature)							
Headache							
Loss of small or taste							
Muscles aches							
Nausea and/or vomiting							
Pains in your chest							
Poor appetite							
Runny or blocked nose							
Sinusitis or facial pain							
Skin rashes							
Sore throat							
Sleep disturbance							
Tender or sore glands in the next							
Vomiting							
White spots on tonsils							

We would like to know about your general health
at the end of week 4

For each question below, please choose the statement that **best describes your health state today**. Please put a cross in ONE box for each question.

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

When you are better (or after 4 weeks)

Did you need to contact any NHS health professionals for further help for this infection? Yes/No

If yes, please tell us who you contacted (tick all those that apply)

GP ☐
Practice Nurse ☐
Pharmacist ☐
NHS 111 ☐
Hospital/A and E ☐
Hospital admission ☐

If hospital admission, how long were you in hospital? ___ days

Was this hospital admission related to a respiratory infection? Yes/No

If yes, what was the reason? _____

Was this hospital admission for COVID-19?

Were you prescribed any medication by your doctor or nurse for this infection? E.g. antibiotics Yes/No

If yes,

What was the name of the medication? _____

How many days did you take the medication?

I took the medication for ___ days OR I did not take the medication ☐

Did you take any time off work or from other activities such as caring for someone? Yes/No

If Yes, how many days off did you have? ____days

Did these infections result in any other costs to you during this time? Yes/No

	Amount that you spent (£/p)
Travel expenses:	
Medication that you bought yourself to help with infections *(E.g. pain medication, cough medicines, syrups, gargles, lozenges, nasal sprays, throat sprays)*	
Prescription charges:	
Childcare costs:	
Private healthcare consultations:	
Private carer costs:	
Other (specify):	

We would like to know about your general health
at the end of your illness or at the end of 4 weeks

For each question below, please choose the statement that **best describes your health state today**. Please put a cross in ONE box for each question.

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

Thank you very much indeed for helping us with the Immune Defence study!

PLEASE RETURN THIS DIARY IN THE FREEPOST ENVELOPE PROVIDED.

Please make sure you have written your initials and postcode on the front of the diary.