**Annexure 4.1: Chikungunya questionnaire form**

**VIRAL DIAGNOSTIC LABORATORY**
**DEPARTMENT OF VIROLOGY, SRI VENKATESWARA UNIVERSITY**
**TIRUPATI-517502**

*Chikungunya questionnaire form*

**Patient information**
- Patient OP No : 
- Name of the patient : 
- Age (in years) : 
- Gender : Male/ Female
- Place of residence : 
- Contact number : 

**Patient family member’s details**

<table>
<thead>
<tr>
<th>SL.No.</th>
<th>Name</th>
<th>Age/Gender</th>
<th>CHIKV declaration</th>
</tr>
</thead>
<tbody>
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**Patient Symptoms (Tick the appropriate one)**
- Fever Yes/No Duration .......... 
- Headache Yes/No Duration ........ 
- Arthralgia Yes/No Duration .......... Intensity of pain Mild/Moderate/Severe 

**Types of joints affected**
- Neck 
- Shoulders 
- Elbow 
- Wrist 
- Small fingers of hand 
- Hip 
- Knees 
- Ankle 
- Feet/toes 
- Rachis 
- Sternocostal joints 
- Morning stiffness Yes/No Duration .......... 
- Joint stiffness Yes/No Duration .......... 
- Sleeping disturbances Yes/No Duration .......... 
- Difficulty in walking Yes/No Duration .......... 
- Myalgia Yes/No Duration .......... 
- Lombalgia Yes/No Duration .......... 

**Oedema Yes/No**
- Joints affected by oedema
  - Face Yes/No Duration .......... 
  - Shoulders Yes/No Duration .......... 
  - Elbow Yes/No Duration .......... 
  - Small fingers of hand Yes/No Duration .......... 
  - Knees Yes/No Duration .......... 
  - Ankles Yes/No Duration .......... 
  - Feet/toes Yes/No Duration .......... 
  - Rash Yes/No Duration .......... 

**Localization of rashes**
- Face Yes/No Duration .......... 
- Trunk Yes/No Duration .......... 
- Hands Yes/No Duration .......... 
- Legs Yes/No Duration .......... 

**Other symptoms**
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Duration</th>
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<tbody>
<tr>
<td>Retroorbital pain Yes/No</td>
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<td>Eye congestion Yes/No</td>
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<td>Chills Yes/No</td>
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<td>Cough Yes/No</td>
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<td>Running nose Yes/No</td>
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<td>Abdominal pain Yes/No</td>
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<td>Nausea Yes/No</td>
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<tr>
<td>Vomiting Yes/No</td>
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<td>Oral ulcers Yes/No</td>
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<td>Weight gain Yes/No</td>
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<tr>
<td>Weight loss Yes/No</td>
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<td>Lethargic Yes/No</td>
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<tr>
<td>Anorexia Yes/No</td>
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<td>Diarrhoea Yes/No</td>
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<td>Giddiness Yes/No</td>
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<td>Any other symptoms specify:</td>
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Source of mosquito breeding sites

**Indoor** Refrigerators/ Coolers/ Indoor plants any others specify........

**Outdoor** Sewage/ Fields any others specify........

Chikungunya is spread by mosquitoes: Yes/No

Preventive Measures

Coils/ Bed nets/ Repellants

Medications/Treatment

Allopathy

Homeopathy

Physiotherapy

Any others specify........

Person completing form: 

Verified by

(Doctoral student)

Name: ................

Designation: ................

Signature: ................

Date: ................

________________________________________________________________________________________________________________________________________

Laboratory report

The patient is positive/ negative for Chikungunya by RT-PCR/IgM strip analysis

(Tick the appropriate one)

Verified by

Signature: ................

(Doctoral student)

Research supervisor & Coordinator

Viral Diagnostic Laboratory
Dept of Virology, Sri Venkateswara University