FORM C: Patient Diary - Tecovirimat Capsules

Instructions for Patients: Remember to take tecovirimat capsules with **a full glass of water** and after eating a **full, fatty meal** (containing about 600 calories and 25 grams of fat). It is important to report any side effects (symptoms you experience) with tecovirimat. Please use this form to record how you feel and any side effects to tecovirimat. When you have completed this form, please send to CDC by uploading to the following secure ShareFile at: https://centersfordiseasecontrol.sharefile.com/r-r3941801ebcbd4002b4dfe98e314ec697.

Patient first and last name:	**Date of birth** (mm/dd/yyyy):
Cellphone number:	**Email address:**
Date of first tecovirimat dose (mm/dd/yy):	**Date of last tecovirimat dose** (mm/dd/yy):
Did you take each dose of tecovirimat with a full, fatty meal? ☐ Yes ☐ No ☐ Don't know	

Progress	**Record Every Day While Taking Tecovirimat**														**After Tecovirimat**
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	7 days after your last dose
Approximate # of lesions															
Any new lesions? (Y/N – if Y, describe on next page)															
Are lesions improving? (Y/N)															
Any pain with lesions? (enter a #) **0:** No pain **1-3**: Mild pain **4-6**: Moderate pain **7-9**: Severe pain **10**: Most severe pain															
Compared to the previous day, are you generally feeling: (enter a #) **1**: Much worse **2**: Worse **3**: About the same **4**: A little better **5**: Much better															

Comments on progress (such as any new or no new lesions, healed lesions)

Side Effects to Tecovirimat: Please indicate whether you experienced any of the following side effects during tecovirimat therapy.		
Nausea ☐ Yes ☐ No	Abdominal Pain ☐ Yes ☐ No	Red or purple spots on the skin ☐ Yes ☐ No
Vomiting ☐ Yes ☐ No	Bruising ☐ Yes ☐ No	Pins and needles sensation ☐ Yes ☐ No
If diabetic and taking repaglinide, experienced low sugar levels? (e.g., shakiness, sweating, hunger, lightheadedness) ☐ Yes ☐ No	Fainting ☐ Yes ☐ No	Seizure ☐ Yes ☐ No
Other, describe:		

List all other medications you were taking while on tecovirimat		
Name of medication	**Dose**	**Dates taken**