1. Personal Information and Diagnosis

Insurance number: ……………………………………………………………………………… … ....

Date of birth: ……………………………… ..

Gender: male / female / no data

Name: ………………………………………………………………………………………… ...

Race: White / Black / Indian / Asian / other: ....

Postal code: …………………………………

Telephone number: …………………………………

Time of questioning:...

Location of questioning: vaccination site / on phone/ other:…..

Way of data collection: retrospective / prospective

2. Details from medical history

2.1 Lifestyle

Occupation: healthcare worker / mental work / manual work / student / retired / unemployed / other:….

Alcohol consumption: yes / no
if yes: frequency: occasionally/monthly/weekly/daily
amount (g/day):…………………………………
since when? (years):…………………………
Alcohol consumption in the last 2 weeks: …………………..

if not: Did you drink alcohol earlier? yes / no
if yes: frequency: occasionally/monthly/weekly/daily
amount (g/occasion):…………………………………
For how many years?………………………………………
How long ago did you stop drinking alcohol?..........................

Guide for estimation of the amount:
1 dl beer (4.5 vol. %) = ~3.5 g alcohol
1 dl wine (12.5 vol. %) = ~10 g alcohol
1 dl hard drink (50 vol. %) = ~40 g alcohol

Smoking: yes / no
if yes: Amount (cigarettes/day):…………………
For how many years? …………………………

if not: Did you smoke earlier? yes / no
if yes: Amount (pcs/occasion):…………………………………
For how many years?………………………………………
How long ago did you stop smoking? ………………………………

Drug abuse: yes / no *Prescribed medication should not be included here.*
if yes: type of drug:……………………………………
Amount:…………………………………………
for how many years:……………………………

Exercise
Do you exercise regularly for more than half an hour? yes / no / no data
if yes: frequency: daily, several times a week, once a week, monthly, less frequently than monthly
Outdoor or indoor?
type: walking / running / swimming / going to the gym / yoga / cycling / wall climbing / martial arts / dancing / gardening / ball game / other:.....
duration of one occasion: .... minutes

2.2 Co-morbidities

Diabetes mellitus: yes / no / no data
if yes: **Type?** Type I / Type II / Type III. / MODY / no data
Date of diagnosis (years)?....................................

Hypertension: yes / no / no data
if yes: **Date of diagnosis (years)?**..................

COPD: yes / no / no data
if yes: **Date of diagnosis (years)?** ....

Asthma: yes / no / no data
if yes: **Date of diagnosis (years)?**.................

Cystic fibrosis: yes / no / no data
if yes: **Date of diagnosis (years)?**................ ..

Other chronic respiratory disease: yes / no / no data
if yes: .... **Date of diagnosis (years)?**..... …… ...

Autoimmune disease: yes / no / no data
if yes: .... **Date of diagnosis (years)?**................

Known underlying immunosuppression: yes / no / no data
if yes: **type**: HIV-positive / long-term glucocorticoids / cyclosporine / azathioprine /other:
Since when (date: year)? ....

Cardiovascular diseases: yes / no / no data
if yes: **type**: IHD / STEMI / NSTEMI / infarction/ angina / heart failure /cardiomyopathy / peripheral vascular disease / other: ....
Since when (date: year)? ....
if heart failure: **NYHA class**: I / II / III / IV.

Cancerous disease: yes / no / no data
if yes: **type of tumor:** brain / thyroid / lung / breast / oral cavity / esophagus / stomach / colon / pancreas / liver / prostate / kidney / bladder / ovary / uterus / lymphoma / leukemia / skin:. other.................
Date of diagnosis (years)? ....
Type? benign / malignant
Currently treated: yes / no

Cirrhosis of the liver: yes / no / no data
if yes: **Date of diagnosis (years)?** ......
Child class: A / B / C

Other chronic liver disease :: yes / no / no data
if yes, please specify ....
Date of diagnosis (years)? .... ………………………....

Dialysis-dependent: yes / no / no data
if yes: **Since when (date: year)?** ... ...

Other chronic kidney disease: yes / no / no data
if yes, please **specify:**............................. ....
Date of diagnosis (years)? ....…

2.3. Other

Do you need oxygen therapy at home? yes / no / no data

Recieved BCG vaccine: yes / no / no data

Did the patient received vaccination other then SARS-CoV-2 vaccine in the last 3 months? yes / no
if yes:
what:….
when:……

Did the patient had any reaction to vaccination ever? yes / no
if yes:

specify:…….

Currently pregnant? yes / no / no data

if yes: week of pregnancy? ………… ..

Are you breastfeeding? yes / no / no data

Have you been hospitalized in the past year? yes / no / no I remember

if yes: **For what reason?** pregnancy / accident / surgery / treatment of my underlying disease / pneumonia / examination / I don't remember anymore, but I was in the hospital

How many times? ……

Did the patient had confirmed COVID positivity? yes /no

if yes:

Date:

Type of test: rapid test / PCR /serology

Did it require treatment in hospital? yes /no

if yes:

How many days:…..

Did it require ICU admission? yes / no

2.4 Medications

Medications taken regularly: yes / no

Please specify the name of the active substance (e.g. “acetylsalicylic acid”). Please specify the amount using the International System of Units –SI (e.g. milligram, gram)

if yes:

name of medication:……….……..

active substance:………………

dose: …………. (number only!)

unit: g / mg / IU / ug / ng

if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……………………

how many times per day (e.g. 3): …………

method of administration: intravenious / intramuscular / oral / enteral / subcutan / inhalation/ transdermal / nasal / rectal / other:….

other notes: ………………………………………

3. Vaccination

Did the patient received SARS-CoV-2 vaccination? yes / no

if yes:

date:

type: Comirnaty (Pfizer, BioNTech) / AstraZeneca, Vaxzevria, Covishield (AstraZeneca)/ Sputnik-V(Gamaleya) / Moderna (Moderna) / BBIBP-CorV (Sinopharm) / Janssen (Jonshon and Jonshon) / CoronaVac (Sinovac) / other:……………..

complication: allergic reaction / other:…..

symptoms after vaccination: yes / no

if yes:

Chills: yes / no / no data

Subfebrility / fever: yes / no / no data
if yes: **Since when?** …………………………… ……
Body Temperature?… ... ºC (axillary / rectal / forehead/ intravascular/ other:……)

Muscle pain: yes / no / no data

Joint pain: yes / no / no data

Weakness, fatigue: yes / no / no data

Fainting / loss of consciousness: yes / no / no data

Dizziness: yes / no / no data

Headache: yes / no / no data

Nausea: yes / no / no data

Vomiting: yes / no / no data
if yes: **How many times**: ……… ....

Decreased appetite: yes / no

Site of vaccination is swollen/painful: yes /no

Diarrhea: yes / no

Sleepiness: yes / no

Sleep disorder: yes /no

Sweating: yes / no

Rash: yes / no

Swollen lymp nodes: yes /no

4. Status: yes / no / no data

Blood pressure: … ...… ..… / ……… .... Hgmm

Heart rate: ……………………….. …… / min

Mean Arterial Pressure (MAP):

Weight:… .. ………………… kg or g

Height: ……… ... ……… cm

BMI

Respiratory rate: ………………....... / min

Body temperature: ………… ..… ° C (axillary / rectal / forehead/ intravascular/ other:……)

Oxygen saturation(SpO2):……….%

Is the patient receiving oxigen therapy or on ventillation? yes/no

Glasgow scale: ……………………

AVPU scale: alert / responding to verbal stimulus / responding to pain / unresponsive

Acute organ failure: yes / no,
if yes, **organ system**: kidney / central nervous system / lungs / circulation / liver

5. Biological samples

Whole blood:	yes / no	if yes:	**date of sampling:**……………………
Serum:	yes / no	if yes:	**date of sampling:**……………………
Plasma:	yes / no	if yes:	**date of sampling:**……………………
Saliva:	yes / no,	if yes:	**date of sampling:**……………………

6. File upload and comments

File upload

Comments: ....