

1. Personal Information and Diagnosis

Insurance number:

Name:

Time of questioning:.....

Has the patient appeared? yes / no

if no, reason: death / no compliance / not available / didn't appear / can't come (due to distance, health problems etc) / hospitalized because of COVID infection / hospitalization because other reason / other:....

if death: **Because of COVID infection or it's complication?** yes / no

2. Changes in details from medical history

2.1 Lifestyle

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

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 since last visit? 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: intravenous / intramuscular / oral / enteral / subcutan /
inhalation/ transdermal / nasal / rectal / other:....
other notes:

3. Vaccination since the last visit

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?... .. °C (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 lymph 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 oxygen therapy or on ventilation? 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: