COVID-19 baseline/post-vaccine infection symptom questionnaire

*All participants receive this questionnaire at baseline visit

Date ____/____/_____

(mm/dd/yyyy)

Questions in this survey are directed at the study participant. If you are the parent or caregiver, please answer the questions on behalf of the individual in the manner in which they would answer.

Patient information

1. Are you the patient [ ] or caregiver/guardian [ ]
    a. Relationship to patient: _____
2. Do you have a primary immunodeficiency or immune dysregulation disorder?
    a. What is your primary immunodeficiency or immune dysregulation disorder? _____
3. Patient age (years): _____
4. Patient sex (assigned at birth): _____
5. Patient race: _____
6. Patient ethnicity: _____
7. Patient blood type (e.g. A, B, O): _____
8. State of residence: _____
9. Do you live in:
    a. [ ] Large city (greater than 500,000 residents)
    b. [ ] Big city (between 100,000 and 500,000 residents)
    c. [ ] Medium-sized city (between 20,000 and 100,000 residents)
    d. [ ] Small town (between 2,500 to 20,000 residents)
    e. [ ] Rural or remote area (under 2,500 residents)

Information about recent illness

10. Have you been tested for SARS-CoV-2 (also called COVID-19)?

    [ ] Yes, once (go to 10a)

    [ ] Yes, more than once (go to 10a)

    a. On approximately which date were you tested most recently?

    ____/____/_____ (mm/dd/yyyy)
    [ ] Don't know or can't remember

    b. Did you test positive?

    [ ] Yes

    [ ] No

    [ ] Have not received test result

    [ ] Don't know

[ ] No

[ ] Don't know

11. Since January 1, 2020, have you been sick for more than one day with an illness that included **any fever**, **cough**, **difficulty breathing, or loss of sense of smell or taste**?

    [ ] Yes

    [ ] No

    [ ] Don't know or can't remember

(If NO or DON'T KNOW/CAN'T REMEMBER, end questionnaire.)

12. Were you sick more than one time between January and now with an illness that included **any fever**, **cough**, **difficulty breathing, or loss of sense of smell or taste**?

    [ ] Yes (go to 12a)

    a. How many times were you ill? ___ times

    [ ] No

    [ ] Don't know or can't remember

(**If YES, complete questions 13 – 21 for the first illness episode <u>and</u> complete Sub-appendix 1 (22 – 30) for each subsequent illness episode. If NO or DON'T KNOW/CAN'T REMEMBER, complete questions 13 – 21 only**)

<u>Specific illness episode</u>

13. When was the first day that you began to feel sick (use calendar)?
    ____/____/_____ (mm/dd/yyyy)

    If you do not remember the exact date, please give month _____ and year _____ and select one of the following:
    [ ] First half of month [ ] Second half of month [ ] Date unknown

14. When was the first day that you began to feel well again (use calendar)?
    ____/____/_____ (mm/dd/yyyy)

    If you do not remember the exact date, please give month _____ and year _____ and select one of the following:
    [ ] First half of month [ ] Second half of month [ ] Date unknown

15. During the time that you were sick, which of the following symptoms did you have that were worse than normal?
    - Fever measured by thermometer [ ] Yes [ ] No [ ] Don't know

      If **<u>YES</u>**, maximum recorded temperature: _____ F / C
    - Felt feverish [ ] Yes [ ] No [ ] Don't know

• Chills	[ ] Yes	[ ] No	[ ] Don't know
• Cough	[ ] Yes	[ ] No	[ ] Don't know
• Sore throat	[ ] Yes	[ ] No	[ ] Don't know
• Runny or stuffy nose	[ ] Yes	[ ] No	[ ] Don't know
• Difficulty breathing	[ ] Yes	[ ] No	[ ] Don't know
• Muscle pain	[ ] Yes	[ ] No	[ ] Don't know
• Chest pain	[ ] Yes	[ ] No	[ ] Don't know
• Abdominal pain	[ ] Yes	[ ] No	[ ] Don't know
• Nausea/vomiting	[ ] Yes	[ ] No	[ ] Don't know
• Diarrhea	[ ] Yes	[ ] No	[ ] Don't know
• Headache	[ ] Yes	[ ] No	[ ] Don't know
• Fatigue	[ ] Yes	[ ] No	[ ] Don't know
• Loss of sense of smell or taste	[ ] Yes	[ ] No	[ ] Don't know
• Rash	[ ] Yes	[ ] No	[ ] Don't know
• Blood clots	[ ] Yes	[ ] No	[ ] Don't know
• Stroke	[ ] Yes	[ ] No	[ ] Don't know
• Low blood oxygen level	[ ] Yes	[ ] No	[ ] Don't know
• Disorientation/delirium	[ ] Yes	[ ] No	[ ] Don't know
• Kidney injury/dysfunction	[ ] Yes	[ ] No	[ ] Don't know
• Other	[ ] Yes	[ ] No	[ ] Don't know

  - specify _____

16. Did you go to a doctor, clinic, or emergency room because of this illness?
    [ ] Yes
    [ ] No
    [ ] Don't know or can't remember

17. Did you receive a diagnosis for this illness??
    [ ] Yes (go to 17a)
        a. Please specify _____
    [ ] No
    [ ] Don't know or can't remember

18. Were you tested for influenza/flu?
    [ ] Yes (go to 18a)

a. What was your test result?

[ ] Positive

[ ] Negative

[ ] Have not received test result

[ ] Don't know

[ ] No

[ ] Don't know

19. Were you tested for SARS-CoV-2 (also called COVID-19)?
[ ] Yes (go to 19a)

a. Did you test positive?

[ ] Yes

[ ] No

[ ] Have not received test result

[ ] Don't know

[ ] No

[ ] Don't know

20. Did you stay overnight in the hospital for this illness?
[ ] Yes (go to 20 a-f)

a. For how many days were you hospitalized? _____ days
b. How many days after your symptoms started were you admitted to hospital?_____ days
c. Do you remember the dates?
Hospital admission ____/____/_____ (mm/dd/yyyy)
Hospital discharge ____/____/_____ (mm/dd/yyyy)
d. Did you receive any treatment for this illness?
[ ] Yes (go to 20d.i)
i. What treatment was received? _____

[ ] No

[ ] Don't know or can't remember

e. Did you require supplemental oxygen?
[ ] Yes
[ ] No
[ ] Don't know or can't remember
f. Did you require mechanical ventilation or extracorporeal membrane oxygenation (ECMO)?
[ ] Yes
[ ] No
[ ] Don't know or can't remember

[ ] No

[ ] Don't know or can't remember

21. [Parent/caregiver] Did this patient die?

[ ] Yes [ ] No

Sub-Appendix 1. Specific illness episodes

Please complete this form for any illness with **any fever**, **cough**, **difficulty breathing, or loss of sense of smell or taste** in addition to the first illness that was indicated on the main questionnaire.

Illness episode #: _____

22. When was the first day that you began to feel sick (use calendar)?
____/____/_____ (mm/dd/yyyy)

If you do not remember the exact date, please give month _____ and year _____ and select one of the following:
[ ] First half of month [ ] Second half of month [ ] Date unknown

23. When was the first day that you began to feel well again (use calendar)?
____/____/_____ (mm/dd/yyyy)

If you do not remember the exact date, please give month _____ and year _____ and select one of the following:
[ ] First half of month [ ] Second half of month [ ] Date unknown

24. During the time that you were sick, which of the following symptoms did you have?

- Fever measured by thermometer [ ] Yes [ ] No [ ] Don't know

  If **YES**, maximum recorded temperature: _____ F / C
- Felt feverish [ ] Yes [ ] No [ ] Don't know
- Chills [ ] Yes [ ] No [ ] Don't know
- Cough [ ] Yes [ ] No [ ] Don't know
- Sore throat [ ] Yes [ ] No [ ] Don't know
- Runny or stuffy nose [ ] Yes [ ] No [ ] Don't know
- Difficulty breathing [ ] Yes [ ] No [ ] Don't know
- Muscle pain [ ] Yes [ ] No [ ] Don't know
- Chest pain [ ] Yes [ ] No [ ] Don't know
- Abdominal pain [ ] Yes [ ] No [ ] Don't know
- Nausea/vomiting [ ] Yes [ ] No [ ] Don't know
- Diarrhea [ ] Yes [ ] No [ ] Don't know
- Headache [ ] Yes [ ] No [ ] Don't know

- Fatigue [ ] Yes [ ] No [ ] Don't know
- Loss of sense of smell or taste [ ] Yes [ ] No [ ] Don't know
- Rash [ ] Yes [ ] No [ ] Don't know
- Blood clots [ ] Yes [ ] No [ ] Don't know
- Stroke [ ] Yes [ ] No [ ] Don't know
- Low blood oxygen level [ ] Yes [ ] No [ ] Don't know
- Disorientation/delirium [ ] Yes [ ] No [ ] Don't know
- Kidney injury/dysfunction [ ] Yes [ ] No [ ] Don't know
- Shock [ ] Yes [ ] No [ ] Don't know
- Myocarditis [ ] Yes [ ] No [ ] Don't know
- Coinfection
    - Viral (e.g. pneumonia) [ ] Yes [ ] No [ ] Don't know
    - Bacterial (e.g. sepsis) [ ] Yes [ ] No [ ] Don't know
- Other [ ] Yes [ ] No [ ] Don't know
    - specify _____

25. Did you go to a doctor, clinic, or emergency room because of this illness?
    [ ] Yes
    [ ] No
    [ ] Don't know or can't remember

26. Did you receive a diagnosis for this illness??
    [ ] Yes (go to 26a)
        a. Please specify _____
    [ ] No
    [ ] Don't know or can't remember

27. Were you tested for influenza/flu?
    [ ] Yes (go to 27a)
        a. What was your test result?
            [ ] Positive
            [ ] Negative
            [ ] Have not received test result
            [ ] Don't know
    [ ] No
    [ ] Don't know

28. Were you tested for SARS-CoV-2 (also called COVID-19)?
    [ ] Yes (go to 28a)
        a. Did you test positive?
            [ ] Yes
            [ ] No
            [ ] Have not received test result
            [ ] Don't know
    [ ] No
    [ ] Don't know

29. Did you stay overnight in the hospital for this illness?
    [ ] Yes (go to 29 a-f)
        a. For how many days were you hospitalized? _____ days
        b. How many days after your symptoms started were you admitted to hospital?_____ days
        c. Do you remember the dates?
           Hospital admission ____/____/_____ (mm/dd/yyyy)
           Hospital discharge ____/____/_____ (mm/dd/yyyy)
           [ ] Do not remember
        d. Did you receive any treatment for this illness?
           [ ] Yes (go to 29d.i)
              i. What treatment was received? _____
           [ ] No
           [ ] Don't know or can't remember
        e. Did you require supplemental oxygen?
           [ ] Yes
           [ ] No
           [ ] Don't know or can't remember
        f. Did you require mechanical ventilation or extracorporeal membrane oxygenation (ECMO)?
           [ ] Yes
           [ ] No
           [ ] Don't know or can't remember
    [ ] No
    [ ] Don't know or can't remember