Post-vaccine adverse events questionnaire

*All participants will receive this within 1 day of each scheduled follow-up sample.

Date ____/____/_____

(mm/dd/yyyy)

Questions in this survey are directed at the person who received the COVID-19 vaccine. If you are the parent or caregiver, please answer the questions on behalf of the individual in the manner in which they would answer.

Vaccine information

1. What day did you receive the COVID-19 vaccine?
   ____/____/_____ (mm/dd/yyyy)
2. Which vaccine did you receive?
   a. [ ] Moderna
   b. [ ] Pfizer
   c. [ ] Johnson and Johnson
   d. [ ] AstraZeneca
   e. [ ] Novavax
3. Which dose is this for?
   a. [ ] Dose 1
   b. [ ] Dose 2

Post-vaccine reactions

4. Since your vaccination, have you had a fever or felt feverish?
   [ ] Yes
      a. Do you know your highest temperature reading from today?
         [ ] Yes
         1. Enter your highest temperature reading from today (degrees Fahrenheit/Celsius): _____
         [ ] No- I don't remember the reading
         [ ] No- I didn't take my temperature
   [ ] No

[*Header text above q5*]

Symptoms can be classified as:

Mild = you notice symptoms, but they aren't a problem

Moderate = symptoms that limit of your normal daily activities

Severe = symptoms make normal daily activities difficult or impossible

5. Have you had any of these symptoms at or near the injection site? select all that apply:

   Pain [ ] None [ ] Mild [ ] Moderate [ ] Severe
   Redness [ ] None [ ] Mild [ ] Moderate [ ] Severe

Swelling [ ] None [ ] Mild [ ] Moderate [ ] Severe
Itching [ ] None [ ] Mild [ ] Moderate [ ] Severe

6. Since your vaccination, have you experienced any of these symptoms? Select all that apply.

Chills	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Headache	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Joint pain	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Muscle or body aches	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Fatigue or tiredness	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Nausea	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Vomiting	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Diarrhea	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Abdominal pain	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Mouth or throat itching/tingling	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Rash, not including the immediate area around the injection site	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Anaphylaxis	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Heart palpitations (racing heart)	[ ] None [ ] Mild [ ] Moderate [ ] Severe
Light-headedness or dizziness	[ ] None [ ] Mild [ ] Moderate [ ] Severe

7. Did your menstrual cycle change? [ ] Yes [ ] No [ ] Don't know [ ] Not Applicable
    a. If yes, has your menstrual cycle changed when you were vaccinated in the past? [ ] Yes [ ] No [ ] Don't know

8. Any other symptoms or health conditions you want to report?
    [ ] Yes
        a. _____
    [ ] No

9. Did you take or receive treatment for any of your symptoms? Select all that apply.
    [ ] Epinephrine
    [ ] Diphenhydramine
    [ ] Famotidine
    [ ] Corticosteroids
    [ ] Supplemental oxygen
    [ ] Albuterol
    [ ] NSAID (Advil, Motrin, etc)
    [ ] Tylenol
    [ ] Other
    [ ] I did not have symptoms

10. How did your symptoms resolve? Select all that apply.
    [ ] Emergency room visit
    [ ] Called 911
    [ ] Self resolved with treatment
    [ ] Self resolved with no treatment
    [ ] I did not have symptoms

11. How long after your vaccination did you experience symptoms? _____ (Time in days)

12. How many days did your symptoms last? _____ (Time in days)

13. Is there anything else you would like to tell us about your symptoms?