Baseline medical history and screening questionnaire

1. In the 14 days before your first COVID-19 vaccines, did you receive any non-COVID-19 vaccinations?

   [ ] Yes (if selected, show 1a-b)

   a. What vaccination?
   b. When did you receive this vaccination? __/__/____ (mm/dd/yyyy)

   [ ] No (skip to 2)

2. In the past 30 days, have you had a blood transfusion?

   [ ] Yes (if selected, show 2a)

   a. When did you receive this transfusion? __/__/____ (mm/dd/yyyy)

   [ ] No (skip to 3)

3. In the past 30 days, have you had any surgical procedures?

   [ ] Yes (if selected, show 3a-b)

   a. What procedure?
   b. When did you undergo this procedure? __/__/____ (mm/dd/yyyy)

   [ ] No (skip to 4)

4. In the past 30 days, have you had any symptoms of infections?

   [ ] Yes (if selected, show 4a-b)

   a. Were you diagnosed?
   [ ] Yes (if selected show 4.a.i)
      i. What was the diagnosis? _____
   [ ] No (skip to 4b)
   b. When did you first see symptoms? __/__/____ (mm/dd/yyyy)

   [ ] No (skip to 5)

5. If female: Are you currently pregnant, breastfeeding, or planning to initiate a pregnancy before day 28 after study vaccination?
   [ ] Yes
   [ ] No
   [ ] Not applicable

6. Planning to receive a non-COVID-19 vaccination in the 28 days after your last COVID-19 vaccine dose?
   [ ] Yes
   [ ] No

<u>Medical history</u>

7. Other immunocompromising condition [ ] Yes [ ] No [ ] Don't know
   - Solid organ transplant [ ] Yes [ ] No [ ] Don't know
   - Stem cell transplant [ ] Yes [ ] No [ ] Don't know
   - Cancer (current/in treatment or diagnosed in last 12 months) [ ] Yes [ ] No [ ] Don't know
   - Other (specify _____) [ ] Yes [ ] No [ ] Don't know
8. Do you have any of the following medical conditions?
   - Seasonal allergies [ ] Yes [ ] No [ ] Don't know
   - Chronic Lung Disease [ ] Yes [ ] No [ ] Don't know
     - Asthma/reactive airway disease [ ] Yes [ ] No [ ] Don't know
     - Emphysema/COPD [ ] Yes [ ] No [ ] Don't know
     - Bronchiectasis [ ] Yes [ ] No [ ] Don't know
     - Other (specify _____) [ ] Yes [ ] No [ ] Don't know
   - Diabetes Mellitus [ ] Yes [ ] No [ ] Don't know
   - Cardiovascular disease [ ] Yes [ ] No [ ] Don't know
     - Hypertension [ ] Yes [ ] No [ ] Don't know
     - Coronary artery disease [ ] Yes [ ] No [ ] Don't know
     - Heart failure/Congestive heart failure [ ] Yes [ ] No [ ] Don't know
     - Cerebrovascular accident/Stroke [ ] Yes [ ] No [ ] Don't know
     - Congenital heart disease [ ] Yes [ ] No [ ] Don't know
     - Other (specify _____) [ ] Yes [ ] No [ ] Don't know
   - Kidney disease [ ] Yes [ ] No [ ] Don't know
     - Dialysis [ ] Yes [ ] No [ ] Don't know
     - Liver disease [ ] Yes [ ] No [ ] Don't know
   - Neurologic/neurodevelopmental disorder [ ] Yes [ ] No [ ] Don't know

     (specify _____)
   - Other chronic diseases [ ] Yes [ ] No [ ] Don't know

     (specify _____)

9. Do you use any of the following medications?
   - No medication/treatment [ ] Yes [ ] No [ ] Don't know
   - Antimicrobials [ ] Yes [ ] No [ ] Don't know
     - Azithromycin (Zithromax) [ ] Yes [ ] No [ ] Don't know
     - Doxycycline [ ] Yes [ ] No [ ] Don't know
     - Minocycline [ ] Yes [ ] No [ ] Don't know
     - Bactrim [ ] Yes [ ] No [ ] Don't know
     - Other oral antibiotics [ ] Yes [ ] No [ ] Don't know
     - Inhaled antibiotics [ ] Yes [ ] No [ ] Don't know
     - Intravenous antibiotics [ ] Yes [ ] No [ ] Don't know
     - Azole (e.g. fluconazole) [ ] Yes [ ] No [ ] Don't know
     - Echinocandin (e.g. caspofungin) [ ] Yes [ ] No [ ] Don't know
     - Amphotericin B
     - Other _____ [ ] Yes [ ] No [ ] Don't know
   - Anticlotting drugs [ ] Yes [ ] No [ ] Don't know
     - Warfarin (Coumadin) [ ] Yes [ ] No [ ] Don't know

- Enoxaparin (Lovenox) injections [ ] Yes [ ] No [ ] Don't know
- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Biological agents [ ] Yes [ ] No [ ] Don't know
- Rituximab [ ] Yes [ ] No [ ] Don't know
- Evusheld [ ] Yes [ ] No [ ] Don't know
- Ocrevus [ ] Yes [ ] No [ ] Don't know
- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Recent blood transfusions [ ] Yes [ ] No [ ] Don't know
• Breathing drugs [ ] Yes [ ] No [ ] Don't know
- Inhaled albuterol (e.g. Ventolin) [ ] Yes [ ] No [ ] Don't know
- Inhaled corticosteroids (e.g. Flovent) [ ] Yes [ ] No [ ] Don't know
- Ipratropium (Atrovent) [ ] Yes [ ] No [ ] Don't know
- Tiotropium (Spiriva) [ ] Yes [ ] No [ ] Don't know
- Hypertonic saline (HyperSal) [ ] Yes [ ] No [ ] Don't know
- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Breathing therapies [ ] Yes [ ] No [ ] Don't know
- Home supplemental oxygen [ ] Yes [ ] No [ ] Don't know
- Airway clearance techniques [ ] Yes [ ] No [ ] Don't know
- Continuous positive airway pressure support (CPAP)

  [ ] Yes [ ] No [ ] Don't know

- Bilevel positive airway pressure support (BiPAP)

  [ ] Yes [ ] No [ ] Don't know

- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Cardiac and blood pressure [ ] Yes [ ] No [ ] Don't know
- ACE inhibitors (e.g. Lisinopril) [ ] Yes [ ] No [ ] Don't know
- Losartan [ ] Yes [ ] No [ ] Don't know
- Metoprolol [ ] Yes [ ] No [ ] Don't know
- Diuretic [ ] Yes [ ] No [ ] Don't know
- Nifedipine [ ] Yes [ ] No [ ] Don't know
- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Diet [ ] Yes [ ] No [ ] Don't know
- Tube feeding [ ] Yes [ ] No [ ] Don't know
- Intravenous nutrition [ ] Yes [ ] No [ ] Don't know
- Special diet (Specify)_____ [ ] Yes [ ] No [ ] Don't know
- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Digestive drugs [ ] Yes [ ] No [ ] Don't know
- Proton-pump inhibitors (e.g. Prilosec) [ ] Yes [ ] No [ ] Don't know
- Famotidine (Pepcid) [ ] Yes [ ] No [ ] Don't know
- Other (specify _____) [ ] Yes [ ] No [ ] Don't know

• Immunoglobulin infusions [ ] Yes [ ] No [ ] Don't know
- Intravenous [ ] Yes [ ] No [ ] Don't know
  - How often do you receive this treatment? _____
- Subcutaneous [ ] Yes [ ] No [ ] Don't know
  - How often do you receive this treatment? _____

- Immunosuppressants [ ] Yes [ ] No [ ] Don't know
  - Azathioprine (Imuran) [ ] Yes [ ] No [ ] Don't know
  - Mycophenolate (CellCept, Myfortic) [ ] Yes [ ] No [ ] Don't know
  - Tacrolimus (Prograf) [ ] Yes [ ] No [ ] Don't know
  - Sirolimus (Rapamune) [ ] Yes [ ] No [ ] Don't know
  - Everolimus (Afinitor) [ ] Yes [ ] No [ ] Don't know
  - Hydroxychloroquine (Plaquenil) [ ] Yes [ ] No [ ] Don't know
  - Other (specify _____) [ ] Yes [ ] No [ ] Don't know
- Steroids [ ] Yes [ ] No [ ] Don't know
  - Oral corticosteroids (prednisone) [ ] Yes [ ] No [ ] Don't know
  - Topical swallowed steroids (fluticasone) [ ] Yes [ ] No [ ] Don't know
  - Nonabsorbable oral steroids (budesonide) [ ] Yes [ ] No [ ] Don't know
  - Nasal topical steroids [ ] Yes [ ] No [ ] Don't know
  - Other (specify _____) [ ] Yes [ ] No [ ] Don't know
- Other drugs (specify _____) [ ] Yes [ ] No [ ] Don't know
- Experimental therapies [ ] Yes [ ] No [ ] Don't know
  - Please list: _____

10. What is your current height?
11. What is your current weight?
12. Do you want to provide any additional information?