

QUESTIONNAIRE FOR PATIENT ATTENDING **DOSE II OF** COVID-19 mRNA VACCINATION

AGE:

GENDER: female, male

Place of residence:

☐ village

☐ city of up to: 50,000 inhabitants ☐ , city of 50,000 to 100,000 ☐ , city of 100,000 to 500,000 ☐ , city of more than 500,000 inhabitants

Number of people living together: **Number of rooms:**.....

Education:

Are you in active employment? ☐ Yes ☐ No

Occupation: doctor, nurse, paramedic, orderly, administrative worker, technical worker (please tick the appropriate one)

What is your blood group?

Do you smoke cigarettes? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No ☐ Occasionally

Do you regularly engage in any sports activities?

Do you regularly vaccinate against influenza?

☐ YES

☐ No (please state the reason).....

Which diseases/pathogens did you vaccinate against as an adult (please tick the appropriate one)

Hepatitis B Hepatitis A Pneumococcus Meningococcus Tetanus Diphtheria

Other.....

Do you regularly take vitamin D3 (in what doses)?

☐ YES

☐ No

Do you take nutritional supplements?

☐ YES,(please specify which ones)

☐ No

Do you suffer from chronic diseases such as, for example, diabetes, hypertension, heart disease, respiratory diseases (e.g. COPD), cancer and others?

☐ Yes, (please specify)

☐ No

Do you take chronic medication?

☐ Yes,(please specify)

☐ No

Do you have a blood coagulation disorder /myelopoiesis, plasma blemishes, congenital thrombosis/ are you taking anticoagulants?

☐ Yes

☐ No

Have you been diagnosed with an immune disorder (primary/ secondary immunodeficiency)?

☐ Yes

☐ No

Are you taking medications with immunosuppressive effects?

☐ Yes

☐ No

Do you suffer from allergic rhinitis and/or conjunctivitis, bronchial asthma, atopic dermatitis, contact dermatitis, angioedema, acute/chronic urticaria?

☐ YES, (please specify the disease)

☐ I have symptoms of one or more of the diseases listed, but have not yet been diagnosed

☐ Not found

Have you ever had any adverse vaccination reactions?

☐ Yes, (please specify which ones and after which vaccine)

☐ No

Have you ever had a serious allergic reaction to drugs/contrast agents/food/insect venom/contact agents e.g. dyes, heavy metals, latex, rubber?

☐ YES,(please specify)

☐ No

Have you ever had an anaphylactic reaction, including anaphylactic shock?

☐ YES, (please specify the triggering factor)

☐ YES, the triggering factor has not been established

☐ NO

Have you ever received adrenaline in your life for the treatment of an allergic reaction?

☐ Yes

☐ No

Do you have a history of SARS-CoV-2 infection?

☐ YES, confirmed by molecular testing (PCR) or antigen test

☐ I had/have typical symptoms of SARS-CoV-2 infection, but without confirmation by laboratory tests

☐ I have a positive titer of anti-CoV IgG antibodies and have had symptoms of infection

☐ I have a positive titer of anti-CoV IgG antibodies, but have had no symptoms of infection

☐ NO

Did you experience any adverse reactions after receiving the first dose of the vaccine; if so, on which day?

☐ Yes

☐ No

	Pain at the injection site	Swelling at the injection site	Redness at the injection site	Pruritus at the injection site	Fatigue	Poor well-being	Shivers	Fever	Muscle/joint pain
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YES									
NO									
Duration									

	Headache	Nausea	Diarrhoea	Enlargement of lymph nodes	Insomnia	Acute peripheral facial nerve palsy	Allergic reaction	Anaphylaxis/anaphylactic shock requiring adrenaline supply
YES								
NO								
Duration								

Have you had any other symptoms of concern not included above within 7/21 days of the first dose?

☐ YES, (please specify) ☐ NO

Have the symptoms listed above affected your life activities?

☐ YES ☐ NO ☐ I did not have any adverse reactions after vaccination

Did you experience symptoms of an allergic reaction within 15-30 minutes after the first dose of the vaccine, such as (please tick the appropriate ones)

☐ Urticaria ☐ Angioedema ☐ Shortness of breath ☐ Rhinitis ☐ Watery eyes ☐ Anaphylactic shock ☐ None of the following

Do you feel apprehensive about the second dose of vaccination against SARS-CoV-2 ?

☐ Yes, greater than before the first dose of the vaccine,(please specify)

☐ Yes, smaller than before the first dose of the vaccine

☐ No

Did you have a test for SARS-CoV-2 infection between the first and second doses of the vaccine?

☐ YES, the result was positive ☐ YES, the result was negative ☐ NO