Patient Questionnaire (Symptoms related to COVID-19 infection)

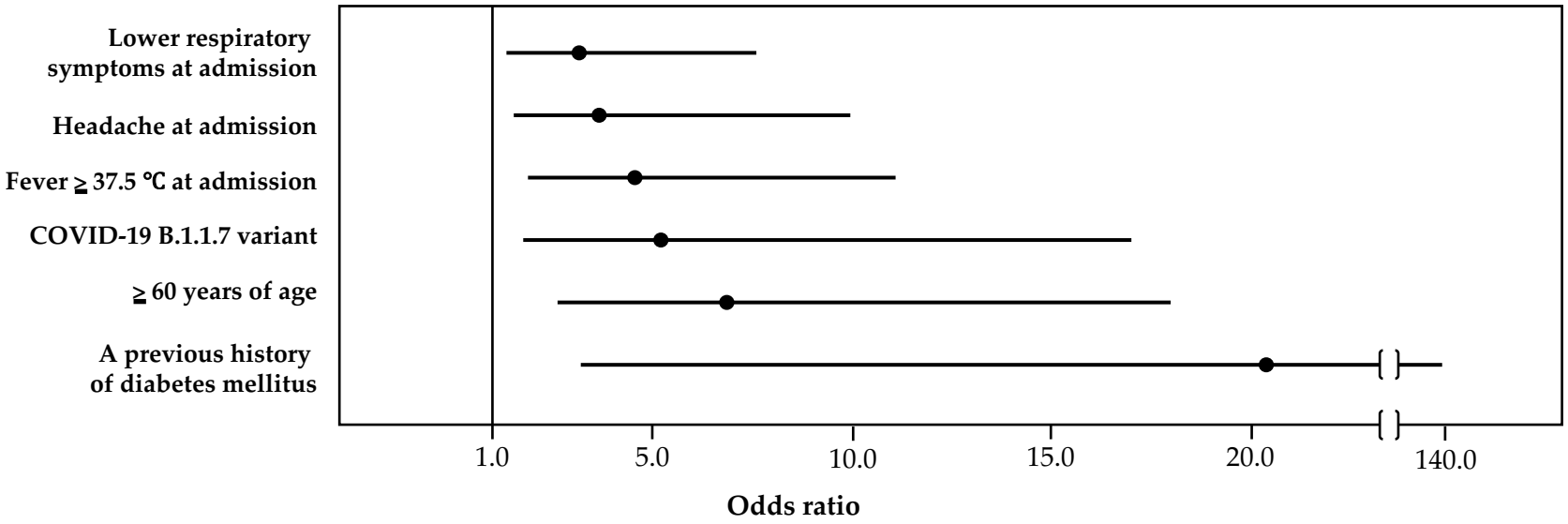
Date:_____

Name:_____ Age:_____

Address:_____ Date of Admission:_____

Please answer the following questions:

1) Do you have runny nose?	□ Yes	□ No
2) Do you have throat pain?	□ Yes	□ No
3) Do you have cough?	□ Yes	□ No
4) Do you have sputum?	□ Yes	□ No
5) Do you have general fatigue?	□ Yes	□ No
6) Do you have headache?	□ Yes	□ No
7) Do you have arthralgia?	□ Yes	□ No
8) Do you have gastrointestinal symptoms?	□ Yes	□ No
9) Do you have loss of smell?	□ Yes	□ No
10) Do you have loss of taste?	□ Yes	□ No
11) Do you have shortness of breath?	□ Yes	□ No



Supplemental Figure S1. Adjusted OR of risk factors for therapeutic intervention of remdesivir among mild to moderate COVID-19 hospitalized patients. Circles represent adjusted OR, error bars represent 95% CI.