Journal of
Clinical Medicine

MDPI

Supplementary Material

Table S1. OSECV Instrument (in Turkish).

1. Demographic Data	
I. Gender	o Female o Male o Non-binary o Prefer not to say
II. Age	o Dropdown menu with numbers (18-99)
III. Profession	o Physician (MD) o Dentist (DDS) o Nurse (BSN) o Midwife o Physiotherapist o If other *(please specify)*
In the case of "Physician (MD)", select your speciality	o Allergology o Anaesthetics o Cardiac surgery o Cardiology o Cardo-thoracic surgery o Chemical pathology o Child and adolescent psychiatry o Clinical oncology o Clinical pharmacology and therapeutics o Clinical radiology o Dermato-venereology o Emergency medicine o Endocrinology o Gastroenterology o General (internal) medicine o General psychiatry o General surgery o Geriatric medicine o Haematology o Histopathology o Immunology o Infectious diseases o Maxillo-facial surgery o Medical microbiology and virology o Nephrology o Neurology o Neuropsychiatry

	o Neurosurgery o Nuclear medicine (Radiation Oncology) o Obstetrics and gynecology o Occupational medicine o Ophthalmology o Orthopedics o Otolaryngology o Pediatric surgery o Pediatrics o Physiotherapy o Plastic surgery o Public health medicine o Respiratory medicine o Rheumatology o Urology o Vascular surgery o If other *(please specify)*
IV. City	o Istanbul o Ankara o Izmir o If other (please specify)
V. Working Experience	o 1 - 5 years o 6 - 10 years o 11 - 20 years o > 20 years
2. Medical Anamnesis	
VI. Do you have any chronic disease?	o Yes o No
If "Yes", please select at least one option from the following	o Asthma o Blood Disorder o Bone Disease o Bowel Disease o Cancer o Cardiac Disease o Chronic Hypertension o Chronic Obstructive Pulmonary Disease (COPD) o Diabetes Mellitus o Renal Disease o Rheumatoid Arthritis o If other *(please specify)*
VII. Do you take any medication currently?	o Yes o No

VIII. If "Yes", please select at least one option from the following	o Antibiotics o Antidepressants o Antihistamine o Immunosuppressive o Narcotic pain medications o Seizure medications o If other *(please specify)*
3. COVID-19-related Anamnesis	
IX. Vaccination Date (first dose)	o Please select the date from the (Calendar)
X. Have you taken the second dose?	o Yes o No
XI. Vaccine Type	Pfizer-BioNTech COVID-19 Vaccine Moderna COVID-19 Vaccine Oxford–AstraZeneca COVID-19 Vaccine Sinovac Vaccine Janssen Vaccine Sputnik Vaccine
XII. Have you ever been diagnosed with COVID-19?	o Yes o No
If "Yes", please specify the day when you recovered	o Please select the date from the (Calendar)
XIII. Have you been exposed to PCR-confirmed COVID-19 cases?	o Yes o No
4. Vaccine Side Effects	
XIV. Within four weeks of receiving the vaccine, have you suffered from any of the following oral symptoms?	o Ulcers o Vesicles o Blisters o A white or red plaque o Unpleasant mouth odour o Bleeding gum o Burning gingiva o Swelling of the lips o If other *(please specify)*
If "Ulcers", "Vesicles" or "blisters", please choose one location at least	o Tongue o Palate o Labial or buccal mucosa o Gingiva o Lips
If "White or red plaque", please choose on location at least	o Tongue dorsum o Soft palate o Labial or buccal mucosa
XV. When did the oral symptoms emerge?	o 1-3 days after vaccination

	o During 1st week of vaccination o During 2nd week of vaccination o During 3rd week of vaccination o During 4th week of vaccination
XVI. Within four weeks of receiving the vaccine, have you suffered from any of the following symptoms?	Injection site pain Injection site swelling Injection site redness Tiredness Headache Nausea Feeling unwell Muscle Pain Chills Joint Pain Fever Swollen lymph nodes (lymphadenopathy) None
XVII. If you chose any of the previous symptoms, please indicate their duration	o 1 day o 3 days o 5 days o 1 week o > 1 week o > 1 month
XVIII. Within four weeks of receiving the vaccine, have you suffered from any severe symptom that required hospitalization, e.g., difficulty in breathing, swelling of face or throat, fast heartbeat, fever, or generalized rash?	o Yes o No
XIX. Within four weeks of receiving the vaccine, have you suffered from any of the following cutaneous symptoms?	o Rash o Urticaria o Angioedema o If other *(please specify)*
In the case of "Rash", "Urticaria", or "Angioedema", please select the affected site	Face Upper limb Lower limb Chest / trunk Back