Questionnaire – Analysis of immune responses and host susceptibility to COVID-19 infection (COVID-19 cases)	**COVID-19 |__|__|__|**

PATIENT INFORMATION

Enrollment Date: |__I__| / |__I__|__| / |__I__|

○ answered by patient ○ answered by family ○ answered by other: _________________

Known source of COVID-19 cluster ○ Yes ○ No ○ Unknown

If yes, specify____

Have a history of returning from abroad after 2020 ○ Yes ○ No ○ Unknown
(If yes, from ____________________ to Thailand at the date |__I__| / |__I__|__| / |__I__|

Have a history of traveling outside the living area within 14 days before onset
○ Yes ○ No ○ Unknown

(If yes, travel to subdistrict:______________ province: ____________Date: |__I__| / |__I__|__| / |__I__|)

Have a history of living in COVID-19 hitting provinces in the past 1 month? ○ Yes ○ No
○ Unknown
(If yes, specify____)

Are you a healthcare worker at risk for COVID-19 infection? ○ Yes ○ No ○ Unknown
If yes, specify detail of work____

COVID-19 vaccination ○ Yes ○ No ○ Unknown
If yes, number of doses received: ○ 1 ○ 2 ○ Unknown

Product name of COVID-19 vaccine_________________

Date of vaccine dose 1: |__I__| / |__I__|__| / |__I__| Date of vaccine dose 2: |__I__| / |__I__|__| / |__I__|

Source of information ○ Documented evidence ○ Recall

completed by __________________ **Date**: |__I__| / |__I__|__| / |__I__| **Time**: |__I__|:|__I__| (24:00)

Questionnaire – Analysis of immune responses and host susceptibility to COVID-19 infection (COVID-19 cases)	**COVID-19 |__|__|__|**

PATIENT INFORMATION

28 DAY VISIT AFTER ENROLLMENT

Date \|__I__\| / \|__I__\|__\| / \|__I__\| ○ **In person** ○ **By phone**

○ **Unable to contact or determine status** ○ **Died; date of death \|__I__\| / \|__I__\|__\| / \|__I__\|**

○ answered by patient ○ answered by family ○ answered by other: __________________

COVID-19 vaccination ○ Yes ○ No ○ Unknown
If yes, number of doses received: ○ 1 ○ 2 ○ Unknown

Product name of COVID-19 vaccine__________________

Date of vaccine dose 1: \|__I__\| / \|__I__\|__\| / \|__I__\| Date of vaccine dose 2: \|__I__\| / \|__I__\|__\| / \|__I__\|

Source of information ○ Documented evidence ○ Recall

Are you taking any medications now? ○ Yes ○ No **If yes, list medications:**

1.	2.
3.	4.

Since you left the hospital, in general do you feel: ○ improved ○ the same ○ worse

Since you left the hospital, have you had any of the following symptoms?			○ Yes ○ No ○ Unknown
○ Fatigue ○ Cough ○ Fever ○ Sore throat ○ Congestion or runny nose ○ Shortness of breath ○ Headache ○ Nausea or vomiting	○ Constipation ○ Diarrhea ○ Weight loss ○Skin rash ○ Hair loss	○ Forgetfulness ○ Difficulty with thinking and concentration ○ Depression ○ Fast-beating or pounding heart (heart palpitations)	○ Chest pain ○ Joint pain ○ Muscle pain ○ pain at other site(s):_____
○ other, describe: ____			

Have you been *diagnosed* with any new medical problems? ○ Yes ○ No **If yes, list problems:**

____

Have you been re-admitted to hospital for any reason? ○ Yes ○ No **If yes, list reason:**

____

Date of re-admission \|__I__\| / \|__I__\|__\| / \|__I__\| **Hospital** ________________________________

Other information, specify____

completed by ___________________ **Date**: \|__I__\| / \|__I__\|__\| / \|__I__\| **Time**: \|__I__\|:\|__I__\| (24:00)

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MAHIDOL UNIVERSITY

Questionnaire – Analysis of immune responses and host susceptibility to COVID-19 infection (COVID-19 cases)	**COVID-19 |__|__|__|**

PATIENT INFORMATION

12 MONTH VISIT AFTER ENROLLMENT

Date \|__I__\| / \|__I__\|__\| / \|__I__\| ○ **In person** ○ **By phone**

○ **Unable to contact or determine status** ○ **Died; date of death \|__I__\| / \|__I__\|__\| / \|__I__\|**

○ answered by patient ○ answered by family ○ answered by other: _________________

COVID-19 vaccination ○ Yes ○ No ○ Unknown
If yes, number of doses received: ○ 1 ○ 2 ○ Unknown

Product name of COVID-19 vaccine_________________

Date of vaccine dose 1: \|__I__\| / \|__I__\|__\| / \|__I__\| Date of vaccine dose 2: \|__I__\| / \|__I__\|__\| / \|__I__\|

Source of information ○ Documented evidence ○ Recall

Are you taking any medications now? ○ Yes ○ No **If yes, list medications:**

1.	2.
3.	4.

Since you left the hospital, in general do you feel: ○ improved ○ the same ○ worse

Since you left the hospital, have you had any of the following symptoms?			○ Yes ○ No ○ Unknown
○ Fatigue ○ Cough ○ Fever ○ Sore throat ○ Congestion or runny nose ○ Shortness of breath ○ Headache ○ Nausea or vomiting	○ Constipation ○ Diarrhea ○ Weight loss ○Skin rash ○ Hair loss	○ Forgetfulness ○ Difficulty with thinking and concentration ○ Depression ○ Fast-beating or pounding heart (heart palpitations)	○ Chest pain ○ Joint pain ○ Muscle pain ○ pain at other site(s):_____
○ other, describe: ____			

Have you been *diagnosed* with any new medical problems? ○ Yes ○ No **If yes, list problems:**

____

Have you been re-admitted to hospital for any reason? ○ Yes ○ No **If yes, list reason:**

____

Date of re-admission \|__I__\| / \|__I__\|__\| / \|__I__\| **Hospital** _________________________________

Other information, specify____

completed by __________________ **Date**: \|__I__\| / \|__I__\|__\| / \|__I__\| **Time**: \|__I__\|:\|__I__\| (24:00)

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