MEDICAL INTAKE FORM

SUBJECT ID#: P126-S00- ☐☐☐☐

This form is completed via interview with the subject at SCREENING and reviewed at BASELINE.

Demographics

Age: ________

Sex: ☐Male ☐Female

Birth date: __ __ / __ __ __ / __ __ __ __ (dd/MMM/yyyy)

Ethnicity: ☐Hispanic or Latino ☐Not reported ☐Not Hispanic or Latino ☐Unknown

Indicate No or Yes for each race listed below. Yes may be checked for more than one race. If a subject refuses to identify his or her race, check No to all options.

American Indian or Alaskan Native: ☐Yes ☐No

Asian: ☐Yes ☐No

Native Hawaiian or other Pacific Islander: ☐Yes ☐No

Black or African American: ☐Yes ☐No

White: ☐Yes ☐No

Occupation: ____

Vaccination History & Other COVID-19 Studies Enrollment Status

Have you received any vaccines in the past month? ☐*Yes ☐No

If *Yes, list vaccines:____

____

COVID-19 vaccine or therapy trial enrollment status:

☐Previously enrolled

☐Currently enrolled

☐Plan to enroll soon (i.e. in the next one or two months)

☐N/A

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Medical History - Comorbidities & Risk Factors

Asthma ☐*Yes ☐No

If *Yes: ☐Well-controlled (defined as <2 days per week etc.) ☐Not well controlled

Pulmonary Disease *Any other pulmonary disease (including emphysema, chronic bronchitis, and interstitial lung disease).*

☐Yes ☐No ☐Ongoing ☐Unknown

Diabetes ☐*Yes ☐No

If *Yes:

Insulin Requiring ☐Yes ☐No

Controlled ☐Well-controlled (HgbA1c<7% in the last 6 months) ☐Not well controlled

Kidney Disease ☐*Yes ☐No

If *Yes:

Severity ☐Mild (GFR <60) ☐Greater than mild

Liver Disease *Any liver disease, including fatty liver disease, cirrhosis, or fibrosis.*

☐Yes ☐No ☐Ongoing ☐Unknown

Cancer *Any type of cancer that is not in complete remission (e.g. excision of basal cell carcinoma, breast mass, benign cancerous lesions) due to total excision of lesion or no evidence of cancer for at least 5 years.*

☐Yes ☐No ☐Ongoing ☐Unknown

Cardiovascular Disease

Question				
Do you have coronary artery disease?	☐Yes	☐No	☐Ongoing	☐Unknown
Have you ever had a heart attack?	☐Yes	☐No	☐Ongoing	☐Unknown
Do you have angina?	☐Yes	☐No	☐Ongoing	☐Unknown
Do you have valvular disease?	☐Yes	☐No	☐Ongoing	☐Unknown
Do you have an abnormal heart rhythm?	☐Yes	☐No	☐Ongoing	☐Unknown
Do you have a pacemaker?	☐Yes	☐No	☐Ongoing	☐Unknown
Any other cardiac disease?	☐*Yes	☐No	☐Ongoing	☐Unknown

If *Yes, ______________________________

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Heart Failure ☐*Yes ☐No

If *Yes:

Severity *Ever diagnosed with greater than or equal to Class 2 heart failure (mild symptoms and slight limitations during normal activity).*

☐Yes ☐No ☐Ongoing ☐Unknown

Hypertension ☐*Yes ☐No

If *Yes:

Severity *Ever diagnosed with Grade 2 (moderate) or 3 (severe) hypertension with blood pressure readings consistently greater than 160/100 mmHg even with the use of medications and lifestyle changes.*

☐Yes ☐No ☐Ongoing ☐Unknown

Immunocompromised State or Immune Modulating Medications *Ever diagnosed with an immunocompromised state or use of immune modulating medications within the last 12 months.*

☐Yes ☐No ☐Ongoing ☐Unknown

Smoking (ever) ☐*Yes ☐No (never smoked)

If *Yes:

Average number of packs per day: ☐ Less than a pack a day **or more**, if more specify # of packs/day _____
Smoking, number of years: _____
Packs/Year history (average # packs per day times # of years smoked): _____
Currently smoking?

☐*Yes ☐*No

If *No, when did you stop: __ __ / __ __ __ / __ __ __ __ (dd/MMM/yyyy)

Vaping (ever) ☐*Yes ☐No

If *Yes: When did you start: __ __ / __ __ __ / __ __ __ __ (dd/MMM/yyyy)

Pregnancy Are you pregnant?

☐Yes ☐No ☐Unknown

Children Do you have any children?

☐*Yes ☐No

If *Yes, how many: ______

What is the age of each child living in your household?

Child 1:____ Child 2:____ Child 3:____ Child 4:____ Child 5:____ Child 6:____ Child 7:____

Number of People How many people are living in your household, including yourself? __________

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Medical History - Comorbidities & Risk Factors - CONTINUED

Anemia	☐Yes ☐No	**High Cholesterol**	☐Yes ☐No
Arthritis	☐*Yes ☐No **If Yes***, specify ☐Inflammatory ☐Non-inflammatory	**HIV/AIDS**	☐Yes ☐No
		Kidney Stones	☐Yes ☐No
Clotting Disorder	☐Yes ☐No	**Stroke**	☐Yes ☐No
Epilepsy	☐Yes ☐No	**Thyroid Disease**	☐Yes ☐No
Other Neurological Disease	☐*Yes ☐No **If *Yes**, specify ________________	**Autoimmune Disease**	☐*Yes ☐No **If *Yes**, specify ________________
Do you have any environmental allergies?	☐*Yes ☐No **If *Yes**, to what: ________________	**Do you have any food allergies?**	☐*Yes ☐No **If *Yes**, to what: ________________
Do you have any medication allergies?	☐*Yes ☐No **If *Yes**, to what: ________________		

Please list any past surgeries you had:

1.	**8.**
2.	**9.**
3.	**10.**
4.	**11.**
5.	**12.**
6.	**13.**
7.	**14.**

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Presence of Any Current Symptoms

Symptoms	Symptoms of fever, cough, anorexia, myalgias, chills, shortness of breath, anosmia, sore throat, rhinorrhea, or diarrhea at enrollment	☐Yes ☐No	☐Ongoing ☐Unknown
Fever	Presence of fever (T > 100.4 °F) on screening vital signs	☐Yes ☐No	☐Ongoing ☐Unknown
COVID-19 Diagnosis	Known prior diagnosis with COVID-19	☐Yes ☐No	☐Ongoing ☐Unknown

Weight and Height Measurement

Was weight assessed? ☐Yes ☐No

If No, reason not done: ☐Subject unable to comply ☐ Investigator decision ☐Subject refusal ☐ Other, specify: ________________

Date assessed: __ __ / __ __ __ / __ __ __ __ (dd/MMM/yyyy)

☐Pounds __ __ __ . __ **lb** OR

☐Kilograms __ __ __ . __ **kg**

Was height assessed? ☐Yes ☐No

☐Inches __ __ __ . __ **in** OR

☐Centimeters __ __ __ . __ **cm**

Body Mass Index (BMI)

BMI: ___ ___

Vital Signs

Respiratory Rate: ___ ___

O_2 Saturations: ___ ___

Any supplemental oxygen? ☐Yes ☐No

Temperature: ___ ___ . ___ ☐°C ☐°F

Heart Rate: ___ ___ ___

Diastolic BP: ___ ___ ___

Systolic BP: ___ ___ ___

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CURRENT MEDICATIONS LIST

☐N/A

____
____
____
____
____
____
____
____
____

PAST MEDICAL HISTORY

☐N/A

____
____
____
____
____
____
____
____
____

ELIGIBILITY

Eligible to participate? ☐Yes ☐No

SEROLOGY RESULTS

IgG ☐Positive ☐Negative

IgM ☐Positive ☐Negative

COMMENTS

____
____
____
____
____

CRC Signature: ______________________________ Date: ________________

CRC Signature: ______________________________ Date: ________________

CRC Signature: ______________________________ Date: ________________

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