Supplementary File 3- COVAD Study Questionnaire

Many countries are actively vaccinating their population against Covid-19 infection, after large clinical trials showed effectiveness and safety of the vaccine. However, the data on effects and safety of the vaccine in patients with autoimmune disease is lacking.

We are a group of doctors and scientists who want to study the effects of Covid-19 vaccine in patients with autoimmune diseases in comparison to healthy individuals. Therefore we want both patients with autoimmune disease as well as without autoimmune disease to take this survey.

This survey takes less than 5 minutes. Your responses are kept confidential and anonymous. We will analyze the data for publication in a medical journal, to discuss the long-term effects and safety of Covid-19 vaccine in these patients.

If you have further questions, please contact Dr. Latika Gupta MD, DM (rheumatologist) drlatikagupta@gmail.com.

* Have you received any dose of any Covid-19 vaccine yet?

- ◯ Yes
- ◯ No

* Why did you not take the vaccine? (multiple answers may be allowed)

- [ ] My doctor has advised against it
- [ ] Not available to me so far but plan to take vaccine as soon as possible.
- [ ] Will not take the vaccine due to long term safety concern or fear.
- [ ] Planning to wait for more time/data regarding safety before I take the vaccine.
- [ ] I have scheduled my vaccine, but not received yet.
- [ ] Not recommended as I had Covid-19 infection recently.
- [ ] I am not sure
- [ ] Other (please specify)

* Did you ever test positive for COVID-19 (Coronavirus)?

- ◯ Yes
- ◯ No

* When did you test positive for COVID-19 (Coronavirus)?
Provide best approximate date if exact date (DD/MM/YYYY) is unknown.

Date

Date

DD/MM/YYYY

* How long did your symptoms last (in days)?
(select 0 if you had no symptoms)

0 100

* What were your symptoms due to Covid-19 infection?

- [ ] None (asymptomatic– no symptoms)
- [ ] Fever
- [ ] Fatigue
- [ ] Muscle aches
- [ ] Cough
- [ ] Breathlessness
- [ ] Chest pain
- [ ] Diarrhea
- [ ] Headache
- [ ] Oral ulcers
- [ ] Nausea/vomiting
- [ ] Joint pains
- [ ] Skin rashes
- [ ] Other (please specify)

* Did you require hospitalization or oxygen supplementation due to Covid-19 infection?

- ◯ Yes – Hospitalization
- ◯ Yes- Hospitalisation and Oxygen supplementation
- ◯ No

* Which vaccine did you take?

- ◯ Pfizer-BioNTech
- ◯ Oxford/Astra Zeneca
- ◯ Johnson & Johnson (J&J)
- ◯ Moderna
- ◯ Novavax
- ◯ Covishield (serum institute India)
- ◯ Covaxin (Bharat Biotech)
- ◯ Sputnik
- ◯ I am not sure which one I received.
- ◯ Other (please specify)

* How many doses have you received ?

◯ 1 ◯ 2

* On which date did you received the first dose of the vaccine ?

DD / MM/YYYY

Date

DD/MM/YYYY

* Did you experience any minor (mild) symptoms within 7 days of vaccination? **(1st or 2nd dose) – choose multiple if more than 1 symptoms.**
Minor symptoms are the ones that resolve within few days with or without medication.

- [ ] None- I did not develop any symptoms after vaccination
- [ ] Injection site (arm) pain and soreness
- [ ] Muscle pain in all arms and legs
- [ ] Body ache
- [ ] Fever
- [ ] Chills
- [ ] Nausea/Vomiting
- [ ] Headache
- [ ] Rash
- [ ] Fatigue
- [ ] Diarrhoea
- [ ] Abdominal pain
- [ ] High pulse rate or palpitations
- [ ] Rise in blood pressure
- [ ] Fainting
- [ ] Difficulty in breathing
- [ ] Dizziness
- [ ] Chest pain
- [ ] Other (please specify)

* Did you experience any major (severe) symptoms within 7 days of vaccination? **(1st or 2nd dose) – choose multiple if more than 1 symptom.**

- [ ] None
- [ ] Anaphylaxis (shock)
- [ ] Marked difficulty in breathing
- [ ] Tongue swelling or throat closure
- [ ] Severe diffuse body rash (hives)
- [ ] Required hospitalisation
- [ ] Other severe symptoms (please specify)

* Do you have any of following autoimmune conditions?
(multiple answers)

- [ ] No autoimmune disease
- [ ] Dermatomyositis
- [ ] Polymyositis
- [ ] Inclusion Body Myositis
- [ ] Anti-synthetase syndrome
- [ ] Necrotizing myositis
- [ ] Juvenile dermatomyositis
- [ ] Mixed Connective Tissue Disease (MCTD)
- [ ] Overlap Myositis with lupus or Sjogren or Systemic sclerosis or Rheumatoid arthritis
- [ ] Systemic Sclerosis (scleroderma)
- [ ] Sjogren syndrome
- [ ] Rheumatoid Arthritis
- [ ] Vasculitis
- [ ] Systemic lupus erythematosus (lupus)
- [ ] Ankylosing Spondylitis or Psoriatic arthritis
- [ ] Crohn’s disease or ulcerative colitis (Inflammatory bowel disease/IBD)
- [ ] Multiple sclerosis
- [ ] Myasthenia gravis
- [ ] Pernicious anemia
- [ ] Hemolytic anemia / idiopathic thrombocytopenic purpura (ITP)
- [ ] Thyroid (Hypothyroid or hyperthyroid)
- [ ] Type 1 Diabetes
- [ ] Polymyalgia Rheumatica (PMR)
- [ ] Other autoimmune disease (please specify)

* Who confirmed your autoimmune disease diagnosis ?

- ◯ Rheumatologist
- ◯ Neurologist
- ◯ Dermatologist
- ◯ Hematologist
- ◯ Physician/Medicine doctor (internal medicine, Internist)
- ◯ Primary care physician (PC), or family doctor or general practioner (GP).
- ◯ Other doctor (specify)

* In which year were you diagnosed with autoimmune disease ?

* Did you have any of the following symptoms in 4 weeks before (prior to) your 1st dose of Covid-19 vaccine. Mark only significant symptoms that affected your day-to-day life.
(multiple answers)

- [ ] I did not have any symptoms
- [ ] Rashes
- [ ] Muscle weakness
- [ ] Joint pain or swelling in hands
- [ ] Joint pain or swelling of other joints
- [ ] Raynaud's (blue, or white discolouration with or without pain in the fingers on exposure to cold)
- [ ] Fingertip ulcers or pits
- [ ] Shortness of breath
- [ ] Chest pain
- [ ] Difficulty in swallowing
- [ ] Fever
- [ ] Fatigue
- [ ] Dry eyes
- [ ] Dry mouth
- [ ] Oral or nasal ulcers (sores)
- [ ] Skin thickening of hands and other areas (if scleroderma)
- [ ] Severe loss of hair or in bald spots
- [ ] Headache due to disease
- [ ] Active kidney disease from autoimmune disease
- [ ] Elevated muscle enzyme in blood (high CK or creatine kinase level)
- [ ] Elevated inflammatory markers in blood (high ESR or CRP)
- [ ] Other (specify)

* What kind of rashes did you notice?

- [ ] I didn't have any rashes
- [ ] Red rash around the eyes
- [ ] Red rashes on the knuckles
- [ ] Rashes on the knees
- [ ] Rashes on the things or/and hips
- [ ] Red rash on the cheeks
- [ ] Red rash in the V area of the chest
- [ ] Red rashes on the outside of arms and/or forearm
- [ ] Mechanic's hand (rough thick scaly skin on the fingers)
- [ ] Other
- [ ] Other red rashes (specify)

* If you have swelling in your joints, how many joints are swollen? (do not count joints with bony enlargement/swelling)

- [ ] I don’t have any swollen joints.
- [ ] 1-2 swollen joints
- [ ] 3-5 swollen joints
- [ ] 5 or more swollen joints

* Were you on any of the following immunosuppressive medications before (within 4 weeks) of vaccination (1st dose)?
(Multiple answers)

- [ ] None
- [ ] Methotrexate
- [ ] Mycophenolate Mofetil or Mycophenolic acid
- [ ] Rituximab
- [ ] Azathioprine
- [ ] Hydroxychloroquine (HCQS, plaquenil)
- [ ] Sulfasalazine
- [ ] Leflunomide
- [ ] Oral Tacrolimus
- [ ] Cyclosporine
- [ ] IV Immunoglobulin (IVIg) or Subcutaneous Immunoglobulin (SQIg)
- [ ] Cyclophosphamide (Cytoxan)
- [ ] Other medicines
- [ ] Other biologics (Specify)

* Were you on any steroids (prednisone, Medrol, prednisolone, wysolone, omacortil, etc} before (within 4 weeks) of vaccination (1st dose)?

- ( ) No steroids
- ( ) Yes, < 10 mg a day
- ( ) Yes, 10 mg - 20 mg a day
- ( ) Yes, > 20 mg a day

* Did you require an increase in the dose of any of these immunosuppressant medications, or starting a new immunosuppressant medicine in the 6 months prior to the 1st Covid-19 vaccine ? (multiple answers). **Do NOT include if dose was decrease or medication stopped.**

- [ ] No
- [ ] Steroids
- [ ] Methotrexate
- [ ] Mycophenolate Mofetil or Mycophenolic acid
- [ ] Rituximab
- [ ] Azathioprine
- [ ] Hydroxychloroquine (HCQS, plaquenil)
- [ ] Sulfasalazine
- [ ] Leflunomide
- [ ] Oral Tacrolimus
- [ ] Cyclosporine
- [ ] IV Immunoglobulin (IVIg) or Subcutaneous Immunoglobulin (SQIg)
- [ ] Cyclophosphamide (Cytoxan)
- [ ] Other medications

* What was the status of your autoimmune disease in 4 weeks (prior to) before 1st dose of Covid-19 vaccine?

- ( ) My disease was inactive or in remission
- ( ) My disease was active but stable and manageable
- ( ) My disease was active and improving
- ( ) My disease was active and worsening
- ( ) I am not sure
- ( ) Other (please specify)

* Did you discontinue or hold any of the above immunosuppressive medication (if taking) days or weeks before or after vaccination?

- ( ) No I continued all medicines as I did before
- ( ) Not applicable (not on any of the above immunosuppressive medications)
- ( ) Yes

* Which medications did you hold for Covid-19 vaccine? (Multiple answers)

- [ ] Steroids
- [ ] Methotrexate
- [ ] Mycophenolate Mofetil or Mycophenolic acid
- [ ] Rituximab
- [ ] Azathioprine
- [ ] Hydroxychloroquine (HCQS, plaquenil)
- [ ] Sulfasalazine
- [ ] Leflunomide
- [ ] Oral Tacrolimus
- [ ] Cyclosporine
- [ ] IV Immunoglobulin (IVIg) or Subcutaneous Immunoglobulin (SQIg)
- [ ] Cyclophosphamide (Cytoxan)
- [ ] Biologics
- [ ] Other immunosuppressive medicines

* How long (days) did you hold approximately?

0 100

* In general, how would you rate your physical health?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

* To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- ◯ Completely
- ◯ Mostly
- ◯ Moderately
- ◯ A little
- ◯ Not at all

* Please rate your overall level of fatigue (tiredness) in the past 7 days by placing a mark on the line below. Zero (0) is no fatigue and 10 is very severe fatigue.

0 10

* Please rate your overall level of pain in the past 7 days by placing a mark on the line below. Zero (0) is no pain and 10 is very severe pain.

0 10

* What is the current status of your physical function?

	Not at all	Very little	Somewhat	Quite a lot	Cannot do
Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	○	○	○	○	○
Does your health now limit you in walking more than a mile (1.6 km)?	○	○	○	○	○
Does your health now limit you in climbing one flight of stairs?	○	○	○	○	○
Does your health now limit you in lifting or carrying groceries?	○	○	○	○	○
Does your health now limit you in bending, kneeling, or stooping?	○	○	○	○	○

* What is the current status of your physical function?

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Cannot do
Are you able to do chores such as vacuuming or yard work?	○	○	○	○	○
Are you able to dress yourself, including tying shoelaces and buttoning your clothes?	○	○	○	○	○
Are you able to shampoo your hair?	○	○	○	○	○
Are you able to wash and dry your body?	○	○	○	○	○
Are you able to sit on and get up from the toilet?	○	○	○	○	○

* Which country do you live in?

* Gender

- Male
- Female
- Do not wish to disclose

* Ethnicity?

- Caucasian (White)
- African American or of African origin (Black)
- Asian
- Other (please specify)
- Hispanic
- Native American/Indigenous/Pacific Islander
- Do not wish to disclose

* Age?

18 100