Supplemental Online Content

Hause AM, Zhang B, Yue X, et al. Reactogenicity of simultaneous COVID-19 mRNA booster and influenza vaccination in the United States. *JAMA Netw Open.* 2022;5(7):e2222241. doi:10.1001/jamanetworkopen.2022.22241

eMethods. v-safe Health Survey Sent During Days 0-7 Following Vaccination

This supplemental material has been provided by the authors to give readers additional information about their work.

eMethods

v-safe Health Survey sent during Days 0-7 following Vaccination

1. How are you feeling today?
    - Good
    - Fair
    - Poor

2. Since your vaccination, have you had a fever or felt feverish?
    - Yes
    - No

    (If Yes) Do you know your highest temperature reading from today?
    - Yes- in degrees Fahrenheit
    - Yes- in degrees Celsius
    - No- I don't remember the reading
    - No- I didn't take my temperature

    Enter your highest temperature reading from today (degrees Fahrenheit): _____

    Enter your highest temperature reading from today (degrees Celsius): _____

3. Have you had any of these symptoms at or near the injection site? Select all that apply.
    - Pain
    - Redness
    - Swelling
    - Itching
    - None

    (For each checked symptom) How would you rate your symptom?
    - Mild = you notice symptoms, but they aren't a problem
    - Moderate = symptoms that limit of your normal daily activities
      Severe = symptoms make normal daily activities difficult or impossible

4. Have you experienced any of these symptoms today? Select all that apply.
    - Chills
    - Headache
    - Joint pain
    - Muscle or body aches
    - Fatigue or tiredness
    - Nausea
    - Vomiting
    - Diarrhea
    - Abdominal pain
    - Rash, not including the immediate area around the injection site

- None

(For each checked symptom) How would you rate your symptom?
- Mild = you notice symptoms, but they aren't a problem
- Moderate = symptoms that limit of your normal daily activities
- Severe = symptoms make normal daily activities difficult or impossible

5. Any other symptoms or health conditions you want to report_____

6. Did any of the symptoms or health conditions you reported TODAY cause you to (select all that apply):
   - Be unable to work or attend school?
   - Be unable to do your normal daily activities?
   - Get care from a doctor or other healthcare professional?
   - None of the above

(If "Get care…" checked) What type of healthcare visit did you have? (check all that apply)
- Telehealth, virtual health, or email health consultation
- Outpatient clinic or urgent care clinic visit
- Emergency room or emergency department visit
- Hospitalization
- Other, describe:
  _____