VACCINATION QUESTIONNAIRE

Patient initials: .....

Physician: .....

Date: .....

Dear Patient,
The Rheumatology department of Ajou University would like to evaluate the prevalance of vaccine reactions in patients with autoimmune rheumatic diseases who had at least 1 dose of a COVID-19 and influenza vaccine. This questionnaire covers questions on possible effects of vaccine as well as information on the course of your underlying rheumatic diseases including the activity of the disease and treatments taken.
We are very grateful that you agreed to complete this survey. All answers are voluntary. If any question causes distress, please discuss it with your doctor, ask help from your doctor instead of leaving unreplied. No personal data such as your name, date of birth, address will be recorded. Your answers will not affect the management of your underlying rheumatic disease in any way. It is an observational (non-interventional) study which means that no treatment will be given. Also, your participation has no impact on any treatment that you may receive for your disease.
The Questionnaire includes 11 questions. Please read each question carefully and check 'V' for the corresponding item. Ask help from your physician or nurse staff if you can not understand each question. It will not take more than 10-15 minutes to complete this questionnaire.

DEMOGRAPHIC DATA

1	**Age**	
2	**Height**	
3	**Weight**	
4	**Gender**	**1** Female **2** Male

1. What kind of autoimmune rheumatic disease do you have? If more than one, please select all.
□ Rheumatoid arthritis
□ Systemic lupus erythematosus
□ Ankylosing spondylitis
□ Adult-onset Still's disease
□ Sjoren's syndrome
□ Vasculitis
□ Polymyositis/dermatomyostis
□ Systemic sclerosis

2. Have you ever had any vaccines since you were 18 years old? If yes, please select all.
□ None
□ Influenza
□ Pneumococcus
□ Zoster
□ Pertussis, diphtheria, and tetanus
□ Hepatitis
□ Human papillomavirus
□ Measles, mumps, and rubella
□ Others, please: _____

3. Have you ever experienced any adverse reactions from past vaccinations selected above?
□ No
□ Yes

3-1. Answer this if you select yes: what kind of vaccines have experienced adverse reactions?
□ Influenza
□ Pneumococcus
□ Zoster
□ Pertussis, diphtheria, and tetanus
□ Hepatitis
□ Human papillomavirus
□ Measles, mumps, and rubella
□ Others, please

3-2. Answer this if you select yes: What type of reaction did you have? (Please tick all that apply)
□ Redness at sites of injection
□ Swelling at sites of injection
□ Pain at sites of injection
□ Headache
□ Fever
□ Myalgia
□ Fatigue
□ Nausea/vomiting
□ Abdoinal pain/diarrhea
□ Generalized edema
□ Disease flare of underlying rheumatic disease
□ Acute allergic reaction
□ Itching □ Urticaria □ Skin rash □ Angioedema □ Cough □ Rhinorrhea □ Dyspnea □ Anaphylaxis
□ Delayed allergic reaction
□ Itching □ Urticaria □ Skin rash
□ Others, please: _____

4. How many doses of vaccine did you get?
□ First dose
□ Second dose
□ Booster dose

4-1. Please fill out the date and type of vaccination.

	First dose	Second dose	Booster dose
Vaccination status	□ Yes □ No	□ Yes □ No	□ Yes □ No
Vaccination Date (mm/dd/yy)			
Type of vaccination	□ BioNTech/Pfizer (BNT162b2)	□ BioNTech/Pfizer (BNT162b2)	□ BioNTech/Pfizer (BNT162b2)
	□ AstraZeneca (ChAdOx1 nCoV-19)	□ AstraZeneca (ChAdOx1 nCoV-19)	□ AstraZeneca (ChAdOx1 nCoV-19)
	□ Moderna (mRNA-1273)	□ Moderna (mRNA-1273)	□ Moderna (mRNA-1273)
	□ Janssen/J&J (Ad26.COV 2.S)	□ Janssen/J&J (Ad26.COV 2.S)	□ Janssen/J&J (Ad26.COV 2.S)
	□ Other _____	□ Other _____	□ Other _____

4-2. If one dose of vaccine, please answer this question: Why did you have one dose of vaccine?'
□ Because specialist recommended me not to get vaccinated
□ Because I had a reaction and was afraid to have the second dose
□ I am afraid though I did not have any reaction at the first dose
□ The time for the second vaccine did not arrive yet
□ Other, please specify _____

5. Have you experienced disease flare of underlying rheumatic disease after COVID-19 vaccination?
□ Yes (Go to question 5-1)
□ No (Go to question 6)

5-1 Please fill out the number of vaccnations and symptoms that have experienced disease flare of rheumatic disease after COVID-19 vaccination.

	First dose	Second dose	Booster dose
Disease flare	□ Yes □ No	□ Yes □ No	□ Yes □ No
When did the reaction heapen?	□ _____hours □ _____days □ _____weeks □ Other, _____	□ _____hours □ _____days □ _____weeks □ Other, _____	□ _____hours □ _____days □ _____weeks □ Other, _____
What type of reaction did you have? (please tick all that apply)	□ Joint pain/swelling	□ Joint pain/swelling	□ Joint pain/swelling
	□ Fever	□ Fever	□ Fever
	□ Skin rash	□ Skin rash	□ Skin rash
	□ Myalgia	□ Myalgia	□ Myalgia
	□ Dryness	□ Dryness	□ Dryness
	□ Thrombocytopenia	□ Thrombocytopenia	□ Thrombocytopenia

5-2 Which treatment were you taking for worsening your symptoms after COVID-19 vaccination?
□ No treatment
□ Self-treatment (□ Corticosteroid □ NSAIDs □ Tylenol)
□ Emergency room visit
□ Additional outpatient visit
□ Hospitalization

6. Have you experienced any reactions after COVID-19 vaccine (other than disease flare)?
□ Yes (Go to question 6-1)
□ No (Go to question 7)

6-1. What type of reaction did you have? (Please tick all that apply)
□ Redness at sites of injection
□ Swelling at sites of injection
□ Pain at sites of injection
□ Headache
□ Fever
□ Myalgia
□ Fatigue
□ Nausea/vomiting
□ Abdoinal pain/diarrhea
□ Generalized edema
□ Disease flare of underlying rheumatic disease
□ Acute allergic reaction
□ Itching □ Urticaria □ Skin rash □ Angioedema □ Cough □ Rhinorrhea □ Dyspnea □ Anaphylaxis
□ Delayed allergic reaction
□ Itching □ Urticaria □ Skin rash
□ Others, please: _____

6-2. Which treatment were you taking for your symptoms after vaccination?
□ No treatment
□ Self-treatment (□ Corticosteroid □ NSAIDs □ Tylenol)
□ Emergency room visit
□ Additional outpatient visit
□ Hospitalization

7. Haver you been vaccinated against influenza for 2021?
□ Yes (Go to question 7-1)
□ No (Go to question 7-2)

7-1. When is the vaccination date? _____mm_____dd_____yy

7-2. If you did not get the influenza vaccination, please answer this question: Why haven't you been vaccinated?'
□ Because specialist recommended me not to get vaccinated
□ Because I had a reaction and was afraid to have any reactions

□ Because I did not feel the need for influenza vaccination
□ Other, please specify _____

8. Have you experienced disease flare of underlying rheumatic disease after influenza vaccination?
□ Yes (Go to question 8-1)
□ No (Go to question 9)

8-1. Please fill out the time and symptoms that have experienced disease flare of rheumatic disease after influenza vaccination.

When did the reaction heapen?	□ _____hours □ _____days □ _____weeks □ Other, _____
What type of reaction did you have? (please tick all that apply)	□ Joint pain/swelling
	□ Fever
	□ Skin rash
	□ Myalgia
	□ Dryness
	□ Thrombocytopenia

8-2. Which treatment were you taking for worsening your symptoms after influenza vaccination?
□ No treatment
□ Self-treatment (□ Corticosteroid □ NSAIDs □ Tylenol)
□ Emergency room visit
□ Additional outpatient visit
□ Hospitalization

9. . Have you experienced any reactions after influenza vaccine (other than disease flare)?
□ Yes (Go to question 9-1)
□ No (Go to question 10)

9-1. What type of reaction did you have? (Please tick all that apply)
□ Redness at sites of injection
□ Swelling at sites of injection
□ Pain at sites of injection
□ Headache
□ Fever
□ Myalgia
□ Fatigue
□ Nausea/vomiting
□ Abdoinal pain/diarrhea
□ Generalized edema
□ Disease flare of underlying rheumatic disease
□ Acute allergic reaction
□ Itching □ Urticaria □ Skin rash □ Angioedema □ Cough □ Rhinorrhea □ Dyspnea □ Anaphylaxis
□ Delayed allergic reaction
□ Itching □ Urticaria □ Skin rash
□ Others, please: _____

9-2. Which treatment were you taking for your symptoms after vaccination?
□ No treatment
□ Self-treatment (□ Corticosteroid □ NSAIDs □ Tylenol)
□ Emergency room visit
□ Additional outpatient visit
□ Hospitalization

10. Have you had COVID-19 infection?
□ No
□ Yes (□ Before vaccination □ After vaccination)

11. Have you had influenza infection?
□ No
□ Yes (□ Before vaccination □ After vaccination)

Thank you for filling the questionnaire.

We really appreciated your effort and the time you devoted to filling the questionnaire. Your participation is important to us. Based on your comments, we will proceed with analysis and exploration to make an effort to help with your treatment.