Baseline Information

Please complete the questionnaire below.

Thank you.

Participant ID:

_____

Timestamp

_____

COVID-19 VACCINATION IMPLEMENTATION IN CANADA

[part_email]

What is your year of birth?

_____

What was your assigned sex at birth?

◯ Male
◯ Female
◯ Prefer to self-describe
◯ Prefer not to answer

How do you describe your assigned sex at birth?

_____

What is your sex now?

◯ Male
◯ Female
◯ Prefer to self-describe
◯ Prefer not to answer

How do you describe your sex now?

_____

Are you an Indigenous person originating from North America?

◯ Yes
◯ No

Which of the following groups do you belong to? (CHECK ALL THAT APPLY)

☐ First Nations
☐ Inuit
☐ Métis
☐ Non-Status First Nations
☐ Other Indigenous
☐ Prefer not to answer

Do you live on- or off- reserve?

◯ On-reserve
◯ Off-reserve
◯ Prefer not to answer

How would you describe your ethnicity or race? (CHECK ALL THAT APPLY)

- ☐ Black/African Descent
- ☐ East Asian - Chinese
- ☐ East Asian - Japanese
- ☐ East Asian - Korean
- ☐ Indigenous (First Nations, Metis, Inuit)
- ☐ Jewish
- ☐ Latino (Latin American, Hispanic Descent)
- ☐ Middle Eastern - Arab
- ☐ Middle Eastern - Other (Iranian/Persian, Egyptian, Kurdish, etc.)
- ☐ South Asian (Bangladeshi, Indian, Pakistani, Sri Lankan, etc.)
- ☐ Southeast Asian - Filipino
- ☐ Southeast Asian - Other (Vietnamese, Cambodian, Malaysian, Laotian, etc.)
- ☐ White/European Descent
- ☐ Other, specify
- ☐ Don't know
- ☐ Prefer not to answer

(categories are in alphabetical order)

Please specify: _____

What are the first three characters of your Postal Code? _____

What is the highest level of education you have completed?

- ◯ Elementary or middle school
- ◯ High school graduation
- ◯ Trade certficate, vocational school, or apprenticeship training
- ◯ Diploma from a community college or CEGEP
- ◯ Bachelor's degree
- ◯ Graduate degree (such as a Masters or Doctorate)
- ◯ Prefer not to answer

(Please select the highest level of education you have COMPLETED.)

Height and Weight

Current Height _____ _____
Current Weight _____ _____

SMOKING STATUS

What is your smoking status?

- ◯ Never Smoked
- ◯ Former smoker
- ◯ Current smoker

As a current smoker, do you smoke:

- ◯ Less than 1 pack/day
- ◯ More than 1 pack/day

MEDICAL HISTORY

Do you have any known drug allergies?	◯ Yes ◯ No
Please specify your allergies:	_____
What symptoms do you typically experience? (CHECK ALL THAT APPLY)	☐ Rash ☐ Hives ☐ Difficulty breathing ☐ Gastrointestinal effects ☐ Other, specify
Please specify other symptoms:	_____
Do you have any medical conditions that may increase risk for severe illness from COVID-19?	◯ Yes ◯ No
Have you been diagnosed with any of the following conditions? (CHECK ALL THAT APPLY)	☐ High Blood Pressure ☐ Diabetes ☐ Asthma ☐ Chronic Obstructive Pulmonary Disorder or other lung disease ☐ Cardiovascular Disease (heart attack, myocardial infarction, angina) ☐ Chronic Kidney Disease ☐ Liver Disease ☐ Cancer ☐ Sickle Cell Anemia or other blood disorder ☐ HIV ☐ Hepatitis C ☐ Stroke or other neurological disorder
Are you taking prescription medications for high blood pressure?	◯ Yes ◯ No
Are you taking prescription medications for diabetes?	◯ Yes ◯ No
Are you taking prescription medications for asthma?	◯ Yes ◯ No
Are you taking prescription medications for COPD or other lung disease?	◯ Yes ◯ No
Are you taking prescription medications for cardiovascular disease?	◯ Yes ◯ No
Are you taking prescription medications for chronic kidney disease?	◯ Yes ◯ No
Are you taking prescription medication for liver disease?	◯ Yes ◯ No

Site	☐ Skin ☐ Breast ☐ Lung ☐ Colon ☐ Pancreas ☐ Liver ☐ Prostate ☐ Kidney ☐ Ovary ☐ Uterus ☐ Cervix ☐ Stomach ☐ Other, specify
Please specify other site:	_____
Are you taking prescription medications for cancer?	◯ Yes ◯ No
Are you taking prescription medications for sickle cell anemia or other blood disorder?	◯ Yes ◯ No
Are you taking prescription medications for HIV?	◯ Yes ◯ No
Are you taking prescription medications for Hepatitis C?	◯ Yes ◯ No
Are you taking prescription medications for stroke or other neurological disorder?	◯ Yes ◯ No
Have you ever had a transplant?	◯ Yes ◯ No
Have you ever needed dialysis?	◯ Yes ◯ No
Do you take corticosteroids, for example, prednisone?	◯ Yes ◯ No

VACCINE INFORMATION

Which vaccine did you receive?	◯ Moderna ◯ Oxford-AstraZeneca ◯ Pfizer-BioNTech ◯ Other, specify ◯ I don't know
Please specify other vaccine:	_____
When did you receive your first COVID-19 vaccination?	_____
If applicable, when are you scheduled to receive your booster vaccination?	_____