COVID-19 DBA Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID-19 infection:

1. Do you have or have you had a confirmed positive COVID infection? yes no
2. What were your presenting symptoms with COVID? (Circle as many as apply)

Fever Chills Muscle aches Shortness of breath No sense of smell or taste

Other symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many days did your fever last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. On what day of the infection did you experience shortness of breath? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Did you require hospitalization? yes no If so, on what day of the infection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Did you require supplemental oxygen? yes no If so, do you know how much oxygen you were on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Did you require admission to the Intensive Care Unit? yes no If so, for how many days? \_\_\_\_\_
6. Did you require ventilator support? yes no If so, for how many days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. If you were hospitalized, how many days were you in the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. If you are steroid dependent, did you require a blood transfusion during your infection? yes no
9. If you are transfusion dependent, did you require an extra blood transfusion during your infection? yes no
10. If you were in remission, did you require a transfusion during your infection? yes no
11. If you had undergone a transplant recently and are still on medications for your transplant, did you require a transfusion? yes no
12. What treatments did you receive for COVID-19?
    1. Remdesivir yes no
    2. Hydroxychloroquine (Plaquenil®) or Chloroquine yes no
    3. Azithromycin (Zithromax®) yes no
    4. Anakinra (Kineret®) yes no
    5. Tocilizumab (Actemra®) yes no
    6. Steroids (Solumedrol, Hydrocortisone, etc.) yes no
    7. Other treatments (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. Do you have any pre-existing conditions? (circle as many as apply)

High blood pressure Diabetes Asthma Known immunodeficiency

Require G-CSF Require IVIG

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you smoke or vape? If so, how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment for DBA at the Time of the COVID-19 Infection:

1. Are you on steroids (Prednisone or Prednisolone)? yes no

Dose of steroids in milligrams \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of steroids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you receiving chronic transfusions? yes no

Amount of blood per transfusion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of your transfusions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you being iron chelated? yes no

The chelating drug you are taking (Circle as many as apply) Exjade Jadenu Desferal Ferriprox

Dose of the drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days per week the drug is given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you in remission and receiving no medications or transfusions for your DBA? yes no

Time you have been in remission \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had a stem cell/bone marrow transplant for your DBA? yes no

Date of your transplant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications for your transplant that you are presently taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Thank you for completing this questionnaire. Please email/scan to** [**mhussain9@northwell.edu**](mailto:mhussain9@northwell.edu) **or** [**mflorento@northwell.edu**](mailto:mflorento@northwell.edu) **or fax to 516-562-1599.**