ANNEX 2
TO THE CONSENT FORM

COVID-19 VACCINATION
ANAMNESTIC SHEET

The vaccinee will fill in this form and review its content with the Health Professionals of the vaccination team.

Name and Surname:	Phone:		
Anamnesis	**YES**	**NO**	**I don't know**
Are you currently sick?			
Do you have a fever?			
Do you suffer from allergies to latex, food, drug or vaccine components? If yes, please specify:……..…… ……...			
Have you ever had a severe reaction after receiving a vaccine?			
Do you suffer from heart or lung disease, asthma, kidney disease, diabetes, anaemia or other blood disorders?			
Are you in a condition of compromised immune system? (for example: cancer, leukaemia, lymphoma, HIV/AIDS, transplant)?			
In the past 3 months, have you taken any medications that weaken the immune system (for example: cortisone, prednisone or other steroids) or anticancer drugs, or have you undergone radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, or have you been given immunoglobulins (gamma) or antiviral drugs?			
Have you had convulsion attack or any problems with your brain or nervous system?			
Have you received any vaccinations in the past 4 weeks? If yes, please specify:..... …….			
For women: - are you pregnant or are you planning to become pregnant in the month following the first or second dose of vaccine?			
- are you breastfeeding?			

Specify below the drugs, and in particular those anticoagulants, as well as natural supplements, vitamins, minerals or any alternative medicines you are taking:

_____
_____
_____
_____
_____

COVID-related anamnesis	YES	NO	I don't know
Have you been in contact with a person infected with Sars-CoV2 or affected by COVID-19 in the last month?			
You have any of the following symptoms:			
Cough/cold/fever/dyspnoea or flu-like symptoms?			
Sore throat/loss of smell or taste?			
Abdominal pain/diarrhoea?			
Abnormal bruising or bleeding/redness of the eyes?			
Have you made any international trip in the last month?			
COVID-19 testing: No recent COVID-19 testing COVID-19 testing negative (Date: _____) COVID-19 testing positive (Date: _____) Waiting for COVID-19 testing (Date: _____)			

Report any other disease or useful information about your state of health

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