QUESTIONNAIRE FOR PATIENTS VACCINATED FOR COVID-19

(The information you provide will be used anonymously)

AGE: _____

WEIGHT: _____

HEIGHT: _____

CORTICOSTEROID THERAPIES: _____

OTHER DRUGS: _____

MESTRUAL REGULARITY: _____

PARITY: _____

PREGNANT OR BREASTFEEDING: _____

PREVIOUS ONCOLOGICAL OR GYNECOLOGICAL PATHOOGIES: _____

PREVIOUS BLOOD DISORDERS: _____

OTHER: _____

1) WHICH VACCINE FOR COVID-19 PERFORMED:

1. Pfizer/BioNTech mRNA vaccine
2. Moderna mRNA vaccine
3. AstraZeneca's recombinant viral vector vaccine

Specify_____

2) HOW MANY DOSES:

1. 1 dose
2. 2 doses
3. 3 doses

Specify_____

3) DO YOU REMEMBER HAVING GYNECOLOGICAL DISORDERS AFTER THE VACCINE?

1. Yes
2. No

Specify_____

4) AFTER WHAT DOSE?

1. 1st dose
2. 2nd dose
3. 3rd dose

Specify_____

5) HOW LONG AFTER ADMINISTRATION OF THE DOSE?

1. One month
2. More than one month
3. Less than one month

Specify_____

6) WHAT KIND OF GYNECOLOGICAL DISORDERS DO YOU REMEMBER HAVING HAD?

1. Menstrual delay
2. Blood losses
3. Other_____

7) HOW LONG DID THEY LAST?

1. One month
2. More than one month
3. Less than one month

Specify_____

8) AS A RESULT OF THESE DISORDERS, HAVE YOU CARRIED OUT ANY INVESTIGATIONS?

1. Outpatient specialist visit
2. Access to the emergency room
3. Consulted the family doctor/gynecologist for short ways
4. Nothing

Specify_____

9) HAVE THE DISORDERS BEEN REPORTED TO A HEALTHCARE PROFESSIONAL?

1. YES
2. NO

Specify_____

10) YOU HAVE DONE:

1. Blood tests
2. Ultrasaund
3. Medications
4. Supplements

Specify_____

11) DO YOU HAVE A REPORTOF THE EXAMS CARRIED OUT?

1. YES
2. NO

Specify_____

12) AFTTER VACCINATION YOU HAD:

1. Pregnancy
2. Miscarriage
3. Birth

Specify_____