APPENDIX I

DATA COLLECTION FORM

Date: ___/___/______  Interviewer: _______________________
ID center: __________  ID paciente: _______________________

Are you using chloroquine or hydroxychloroquine for more than 30 day?  
1. Yes ( )  2. No ( )

If not, interrupt the questionnaire and do not interview the contacts.

1. Sociodemographic data

1.1. Name:

1.3. Phone:

1.4. City:

1.5. Age:

1.6. Referred weight:

1.7. Hospital where you follow up:

1.8. Sex:  
1.9. Degree of education:  
1.10. Profession: 

1.11. How many people live in your house?  
1. Alone ( )  2. 1 Person ( )  3. 2 or 3 ( )  4. 4 or more ( )

2. About the antimalarial in use:

2.1. Which antimalarial drug is currently in use?

1. Hydroxychloroquine 400 mg ( )  2. Chloroquine diphosphate 150 mg ( )  3. Chloroquine diphosphate 200 mg ( )

4. Chloroquine diphosphate 250 mg ( )  5. Chloroquine (base salt) 150 mg ( )

2.2. Usage time: __________ months

2.3. Frequency (days of use / week)  
1. 7 days / week ( )
2. 6 days / week ( )
3. 5 days / week ( )
4. 4 days / week ( )
5. 3 days / week ( )

2.3.1 Acquisition (dosage ______ mg)

1. Pharmacy purchase ( )
2. SUS ( )
3. Manipulated ( )
4. Others ( )

2.4. Rheumatic disease for which the antimalarial was indicated:

2.4.1. Systemic lupus erythematosus ( )
2.4.2. Systemic sclerosis ( )
2.4.3. Rheumatoid arthritis ( )
2.4.4. Cutaneous lupus ( )
2.4.5. Dermato / polymyositis ( )
2.4.6. Osteoarthritis ( )
2.4.7. Sjogren's syndrome ( )
2.4.8. Mixed Connective Tissue Disease ( )
2.4.9. Chikungunya (cronic) ( )

Other:

2.5. Comorbidities

2.5.1 Systemic arterial hypertension  
1. Yes ( )  2. No ( )

2.5.2 Diabetes  
1. Yes ( )  2. No ( )

2.5.3 Lung disease  
1. Yes ( )  2. No ( )

2.5.4. Heart disease  
1. Yes ( )  2. No ( )

2.5.5. Kidney disease  
1. Yes ( )  2. No ( )

2.5.6. Others. Which one?

2.5.7. Current smoking  
1. Yes ( )  2. No ( )
2.6.1. Oral corticosteroids
2.6.2. Cyclophosphamide
2.6.3. Mycophenolate mofetil
2.6.4. Sulfasalazine
2.6.5. Azathioprine
2.6.6. Anti-TNF
2.6.7. Cyclosporine
2.6.8. Tofacitinib
2.6.9. Rituximab
2.6.10. Tocilizumab
2.6.11. Belimumab
2.6.12. Leflunomide
2.6.13. Anti-inflammatory
2.6.14. Abatacept
2.6.15. Methotrexate
2.6.16. BRA
2.6.17. Angiotensin-converting enzyme inhibitors

2.6.1.1 Pulse therapy with metiprednisolone
2.6.2.1. Pulse therapy with cyclophosphamide
2.6.4. Sulfasalazine
1. Yes (    )   2. No (    )

3. Epidemiological Information
3.1. Had contact with any suspected or confirmed case of coronavirus infection? 1. Yes (    )   2. No (    )
3. Don’t Know (    )
3.2. If so, where did that contact occur?
1. During trip to endemic area (    ) 2. At home (    ) 3. At work (    ) 4. Unknown (    )
Have you had or are you infected with coronavirus? 1. Yes (    )   2. No (    )
Continue only if the answer is yes. If the answer is no, go to item 6.

4. Characteristics of coronavirus infection
4.1 Did you have symptoms suggestive of coronavirus infection?? 1. Yes (    )   2. No (    )
4.2 If you HAD SYMPTOMS, indicate which:
4.2.1 Fever 1. Yes (    )   2. No (    )
4.2.2 Headache 1. Yes (    )   2. No (    )
4.2.3 Cough 1. Yes (    )   2. No (    )
4.2.4 Dizziness 1. Yes (    )   2. No (    )
4.2.5 Dyspnea 1. Yes (    )   2. No (    )
4.2.6 Diarrhea 1. Yes (    )   2. No (    )
4.2.7 Coryza 1. Yes (    )   2. No (    )
4.2.8 Nausea 1. Yes (    )   2. No (    )
4.2.9 Asthenia 1. Yes (    )   2. No (    )
4.2.10 Vomit 1. Yes (    )   2. No (    )
4.2.11 Sore throat 1. Yes (    )   2. No (    )
4.2.12 Loss of smell 1. Yes (    )   2. No (    )
4.2.13 Decreased taste 1. Yes (    )   2. No (    )
4.2.14 Others (please describe):
4.3. Symptom onset date:
4.4. Duration of symptoms; _______ days (if you have no symptoms, put 0)
4.5. Still showing symptoms: 1. Yes (    )   2. No (    ) 3. Had no symptoms (    )
4.6. Hospital internment: 1. Yes (    )   2. No (    )
Date of admission: ___/___/_______
Date of hospital discharge: ___/___/_______
4.6.1 Emergency Room (    ) Infirmary (    ) Intensive care unit (    )
4.6.2 Did you need a breathing apparatus?? 1. Yes (    )   2. No (    )
4.7. Death 1. Yes (    )   2. No (    ) Data of death: ___/___/_______
5. Laboratory Alteration:

5. Was the diagnosis confirmed by the PCR test?: 1. Yes ( ) 2. No ( ) 3. Unrealized ( ) 4. Others ( )

6. Assessment of rheumatic disease

6.1. Was your rheumatic disease well controlled before the coronavirus epidemic?
1. Yes ( ) 2. Partially ( ) 3. No ( ) 4. I don’t Know ( )

6.2. Were symptoms worsening after coronavirus infection?
1. Yes ( ) 2. No ( ) 3. I can’t correlate to the infection

6.3. Was there a change in treatment after the onset of flu-like symptoms?
1. Yes ( ) 2. No ( ) 3. I had no symptoms ( )

6.4. If yes, indicate which change
1. Dose of the drug ( ) 2. Drug suspension ( ) 3. Therapeutic scheme ( )

7. Contact information

7.1. How many people have had or are infected with coronavirus in your home?

7.2. Have you had any contact with a suspected or confirmed case of coronavirus infection? 1. Yes ( ) 2. No ( ) 3. Don’t Know ( )

7.3. If so, where did that contact occur?
1. During trip to endemic area ( ) 2. At home ( ) 3. At work ( ) 4. Unknown ( )

7.4. If the contact was at home, what are the symptoms?

7.4.1. Fever
1. Yes ( ) 2. No ( )

7.4.3. Cough
1. Yes ( ) 2. No ( )

7.4.5. Dyspnea
1. Yes ( ) 2. No ( )

7.4.7. Coryza
1. Yes ( ) 2. No ( )

7.4.9. Asthenia
1. Yes ( ) 2. No ( )

7.4.11. Sore throat
1. Yes ( ) 2. No ( )

7.4.13. Decreased taste
1. Yes ( ) 2. No ( )

7.4.14. Others (please describe): 

7.5. Symptom onset date:

7.6. Duration of symptoms: _______ days (if you have no symptoms, put 0)

7.7. Still showing symptoms: 1. Yes ( ) 2. No ( ) 3. Had no symptoms ( )

7.8. Hospital internment
1. Yes ( ) 2. No ( )

Date of admission: / / 

Date of hospital discharge: / / 

7.8.1. Emergency Room ( ) Infirmary ( ) Intensive care unit ( )

7.8.2. Did you need a breathing apparatus? 1. Yes ( ) 2. No ( )

7.8.2. Death 1. Yes ( ) 2. No ( )

Data of death: / / 

Contact 1 and 2

7.4.2. Headache
1. Yes ( ) 2. No ( )

7.4.4. Dizziness
1. Yes ( ) 2. No ( )

7.4.6. Diarrhea
1. Yes ( ) 2. No ( )

7.4.8. Nausea
1. Yes ( ) 2. No ( )

7.4.10. Vomit
1. Yes ( ) 2. No ( )

7.4.12. Loss of smell
1. Yes ( ) 2. No ( )

7.4.14. Others (please describe):

Date of admission:

Date of hospital discharge: