DATE	……..	
NAME	……..	
GENDER	❑ Female ❑ Male	
AGE	……..	
BODY MASS	……..	
HEIGHT	……..	
ESRD underlaying condition	❑ Diabetic kidney disease ❑ Hypertensive nephropathy ❑ Glomerulonephritis ❑ Cystic/hereditary ❑ Unknown ❑ Other: ……	
Renal replacement therapy:	❑ Hemodialysis Start date: ……	
Concomitant diseases:	❑ Myocardial infarction ❑ Congestive heart failure ❑ Peripheral vascular disease ❑ Cerebrovascular accident ❑ Transient ischemic attack ❑ Dementia ❑ Chronic obstructive pulmonary disease ❑ Connective tissue disease ❑ Peptic ulcer disease ❑ Diabetes mellitus ❑ uncomplicated ❑ end-organ damage ❑ Hemiplegia ❑ Chronic kidney disease	❑ Liver disease ❑ mild = chronic hepatitis (or cirrhosis without portal hypertension) ❑ moderate = cirrhosis and portal hypertension but no variceal bleeding history ❑ severe = cirrhosis and portal hypertension with variceal bleeding history ❑ Solid tumor ❑ localized ❑ metastatic ❑ Leukemia ❑ Lymphoma ❑ AIDS ❑ Other: ……
Kidney transplantation	Date: …….. Donor ❑ Living donor ❑ Deceased donor Serum creatinine prior to COVID-19: ……..	
Immunosuppressive regimen prior to COVID-19:	❑ Steroids ❑ Tacrolimus ❑ Cyclosporine A ❑ MMF/MPA ❑ Azathioprine ❑ Sirolimus ❑ Everolimus	
Immunosuppressive regimen modification after onset of SARS-CoV-2 infection:	❑ Dose reduction Drug name: …….. Dose prior to reduction…… Dose after reduction…… ❑ Drug withdrawal Drug name: …….. ❑ Other: ……..	

SARS-CoV-2 vaccinations (brand name, dates):	❑ YES ❑ 1 dose (date) ……. brand name …….. ❑ 2 doses (date) …… brand name …….. ❑ 3 doses (date) …… brand name…… ❑ 4 doses (date) …… brand name ……	❑ NO
SARS-CoV-2 vaccinations (side effects):	❑ Pain at the injection site dose number(s):…… ❑ Fatigue dose number(s):…… ❑ Headache dose number(s):…… ❑ Muscle aches dose number(s):…… ❑ Arthralgia dose number(s):…… ❑ Chills dose number(s):……	❑ Fever dose number(s):…… ❑ Swelling at the injection site dose number(s):…… ❑ Redness at the injection site dose number(s):…… ❑ Nausea dose number(s):…… ❑ Enlarged lymph nodes dose number(s):…… ❑ Feeling unwell dose number(s):……
COVID-19:	date of the symptoms onset: …….. symptoms duration (days): …….. date of the positive test: …….. hospitalization due to COVID-19 ❑ YES ❑ NO oxygen therapy ❑ YES ❑ NO minimal oxygen saturation (%)……	
COVID-19: symptoms	❑ anosmia ❑ dyspnea ❑ fever ❑ cough ❑ muscle and join pain ❑ weakness ❑ diarrhea ❑ dizziness ❑ skin hyperalgesia ❑ headaches ❑ memory impairment ❑ concentration problems	
MOLNUPIRAVIR THERAPY:	date of distribution: …….. missed doses ❑ YES ❑ NO if yes, why …….. premature therapy discontinuation: ❑ WHEN: …… ❑ WHY: ……	
MOLNUPIRAVIR THERAPY - side effects:	❑ diarrhea ❑ nausea ❑ vomiting ❑ dizziness	❑ headaches ❑ rash ❑ other (please describe): ……..