

File S1: baseline questionnaire for the study

“Antibody response after anti-SARS-CoV-2 vaccination in healthcare operators and possible associated factors”

DATE [][]/[][]/[][][][]

Gender ☐ M ☐ F ☐ Other

Date of birth _____

Country of birth _____

Height _____ Weight _____

ANTI-COVID-19 VACCINATION: ☐ NO ☐ YES

If yes, DATE 1° DOSE [][]/[][]/[][][][]

If yes, DATE 2° DOSE [][]/[][]/[][][][]

TYPE OF ANTI-COVID-19 VACCINE:

☐ COMIRNATY (Pfizer-BioNtech) ☐ Moderna ☐ Astra-Zeneca

☐ Other:

HEALTH

Are you a current smoker? ☐ NO ☐ YES If yes, since how many years? _____ n°
cigarettes/day _____

Do you usually drink alcohol? ☐ NO ☐ YES

If YES, how frequently on a weekly basis do you take 1 o 2 alcoholic units per day? _____

☐ only occasionally And how frequently on a weekly basis do you take 3 or more alcoholic units
per day? _____ ☐ only occasionally

*(please note: 1 alcoholic unit is a standard glass of wine – 0.25 l - or a small glass of spirit – 0.10 l -
or a medium glass of beer – 0.4 l)*

Are you affected by diabetes? ☐ NO ☐ YES

Are you affected by respiratory diseases? ☐ NO ☐ YES

If YES, which disease(s)? _____

Are you affected by cardiovascular diseases? ☐ NO ☐ YES

If YES, which disease(s)? ☐ Hypertension ☐ other cardiovascular disease(s) _____

Are you affected now or were you affected by neoplastic diseases? ☐ **NO** ☐ **YES**

If YES, which disease(s)? _____ If yes, when did you undergo the last therapy for this/these disease(s) _____

Are you affected by other diseases? ☐ **NO** ☐ **YES**

If YES, which disease(s)? _____

Do you usually assume drugs for any of all the disease(s) mentioned above (if any)? ☐ **NO** ☐ **YES**

If YES, which drug(s)? _____

In general, during the last year did you take any drug(s) for a long time (at least more than 2 weeks)? ☐ **NO** ☐ **YES**

If YES, which drug(s)? for how long? _____

Do you remember your latest vaccination before the anti-COVID-19 one? ☐ **NO** ☐ **YES**

If YES, which vaccination? _____ When were you vaccinated? _____

Did you experience any of the following symptoms during the last year?

☐ cough ☐ cold ☐ sore throat ☐ tiredness ☐ diffuse joint/muscle pains ☐ slightly increased body temperature (about 37.5-38°C) ☐ highly increased body temperature (>38°C)
☐ impossibility/difficulty to recognize: ☐ tastes ☐ smells ☐ other symptoms which I believe can be relevant with respect to COVID-19: _____

Were you diagnosed with COVID-19 (please note: we mean that you had a confirmed positive diagnostic swab) during the last year? ☐ **NO** ☐ **YES** If YES, do you remember when? (date) _____

And when did you get the negative swab and/or you were confirmed as negative for COVID-19? _____

Before today, and before the anti-COVID-19 vaccination, did you have at least one serological test to evaluate the presence of anti-SARS-CoV-2 antibodies IgG and/or IgM during the last year?

☐ **NO** ☐ **YES**

If YES, do you remember the latest test you had with a negative result (i.e. with no or insufficient detection of antibodies)? (date) _____ ☐ never had a negative serological test

If YES, do you remember the latest test you had with a positive result (i.e. with detection of antibodies)? (date) _____ ☐ never had a positive serological test

In case you were diagnosed with COVID-19, was this diagnosis reported to the national workers' compensation authority as a work-related infection? ☐ **NO** ☐ **YES** If YES, do you remember when? (date) _____

In case you were diagnosed with COVID-19 and had symptoms, did you had to undergo oxygen support therapy for respiratory fatigue? ☐ **NO** ☐ **YES**

In case you were diagnosed with COVID-19 and had symptoms, were you hospitalized?

☐ **NO** ☐ **YES** If YES, how long have you been to the hospital? _____

WORK

JOB TASK _____

Does your job include shifts? ☐ **NO** ☐ **YES** If YES, do you perform also night shifts? ☐ **NO** ☐ **YES**

If you perform nightshifts, how many of them did you perform during the last year?

☐ less than 20 ☐ 21-40 ☐ 41-60 ☐ 61-80 ☐ 81-100 or more

Due to your job, did you assist COVID-19 patients during the last year? ☐ **NO** ☐ **YES**

During the last year, did you follow specific training for the prevention of the COVID-19 risk at work? ☐ **NO** ☐ **YES**

Due to your job, did you experience any occupational injury at risk for the transmission of an infectious agent (e.g. needle stick injury) during the last year and consequently you had to undergo a profilactic therapy for the prevention of: HIV infection ☐ **NO** ☐ **YES** HBV infection ☐ **NO** ☐ **YES** TETANUS infection ☐ **NO** ☐ **YES**

During the last year, how frequently did you use the following Personal Protective Equipment at work:

DPI	NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS
Surgical mask					
Protective respiratory mask (type FFP2/N95 and/or FFP3/N98)					
Disposable gloves (One pair at a time)					
Disposable gloves (Two pairs at a time)					
Waterproof overcoat					
Overshoes					
Protective glasses					
Visor					
Protective headgear					
Other 1 (please indicate here _____)					
Other 2 (please indicate here _____)					

File S2: follow-up questionnaire for the study "Antibody response after anti-SARS-CoV-2 vaccination in healthcare operators and possible associated factors "

DATE [][]/[][]/[][][][]

Gender M F Other

Date of birth _____ Country of birth _____

ANTI-COVID-19 VACCINATION: NO YES

If yes, DATE 1° DOSE [][]/[][]/[][][][]

If yes, DATE 2° DOSE [][]/[][]/[][][][]

TYPE OF ANTI-COVID-19 VACCINE: COMIRNATY (Pfizer-BioNtech) Moderna Astra-Zeneca

☐ Johnson & Johnson ☐ Other:

HEALTH

During the last 6 months (i.e. after our previous investigation and the anti-COVID-19 vaccination) had you any new diagnosis for disease(s) other than COVID-19? ☐ **NO** ☐ **YES**

If YES, which disease(s)? _____

Did you experience any of the following symptoms during the last 6 months (i.e. after our previous investigation and the anti-COVID-19 vaccination)? ☐ cough ☐ cold ☐ sore throat ☐ tiredness ☐ diffuse joint/muscle pains ☐ slightly increased body temperature (about 37.5-38°C) ☐ highly increased body temperature (>38°C) impossibility/difficulty to recognize: ☐ tastes ☐ smells ☐ other symptoms which I believe can be relevant with respect to COVID-19:

Were you diagnosed with COVID-19 (please note: we mean that you had a confirmed positive diagnostic swab) during the last 6 months (i.e. after our previous investigation and the anti-COVID-19 vaccination)? ☐ **NO** ☐ **YES** If YES, do you remember when? (date) _____

If YES, can you estimate when, taking as a reference the latest vaccine dose before the infection, were you diagnosed with COVID-19? (please indicate here how many days after the first/second vaccine dose) _____

If YES, was the condition you experience with COVID-19 this time a symptomatic one? ☐ **NO** ☐ **YES** If YES, which symptom(s)? _____

In case you were diagnosed with COVID-19 during the last 6 months (i.e. after our previous investigation and the anti-COVID-19 vaccination), did you had to undergo oxygen support therapy for respiratory fatigue? ☐ **NO** ☐ **YES**

In case you were diagnosed with COVID-19 during the last 6 months (i.e. after our previous investigation and the anti-COVID-19 vaccination), were you hospitalized?
☐ **NO** ☐ **YES** If YES, how long have you been to the hospital? _____