| CASE REPORT FORM | Site number – Patient Number | Screening Visit |
|---|---|---|
| | _ _ - _ _ _ _ _ | |

| | |
|---|---|
| Date of visit | _ _ - _ _ - _ _ _ _ (DD/MM/YYYY) |
| Date of informed consent signed | _ _ - _ _ - _ _ _ _ (DD/MM/YYYY) |

| **Eligibility Criteria** | |
|---|---|
| What is the patient's age? | **_ _ (Years)** |
| Does the patient pregnant? | □ **Yes** □ **No** |
| Does the patient currently on lactation? | □ **Yes** □ **No** |
| Did the patient receive any vaccination in 4 weeks ago? | □ **Yes** □ **No** |
| Did the patient plan to receive any vaccination within 3 weeks from now? | □ **Yes** □ **No** |
| In the past 6 months, Did the patient receive any influenza vaccine? | □ **Yes** □ **No** |
| Did the patient diagnosed as influenza the past 6 months? | □ **Yes** □ **No** |
| Did the patient have any chronic illness or underlying disease? | □ **Yes** □ **No** |
| Body temperature at visit | **_ _. _ ºC** |
| **Laboratory Result** | |
| Pregnancy test | □ **Positive** □ **Negative** □ **Not done** |

| CASE REPORT FORM | Site number – Patient Number | Enrollment Visit |
|---|---|---|
| | _ _ - _ _ _ _ _ | |

| Date of visit | _ _ - _ _ - _ _ _ _ (DD/MM/YYYY) |
|---|---|
| **Demographic data** | |
| What is the patient's year of birth? | _ _ _ _ (YYYY) |
| What is the patient's age? | _ _ (Years) |
| What is the sex of the patient? | □ Male □ Female |
| **Physical examinations** | |
| What is the patient height? | _ _ _ cm. |
| What is the patient weight? | _ _ _ kg. |
| **Vital sign** | |
| Blood pressure | _ _ _ / _ _ _ mmHg<br>(Systolic / Diastolic) |
| Respiratory rate | _ _ / min<br>(respiratory rate per minute) |
| Body temperature | _ _. _ $^{o}$C |
| Pulse rate | _ _ bpm<br>(pulse rate per minute) |
| **Examination** | |
| HEENT | □ Normal<br>□ Abnormal, specify _____ |
| Cardiovascular | □ Normal<br>□ Abnormal, specify _____ |
| Chest | □ Normal<br>□ Abnormal, specify _____ |
| Abdomen | □ Normal<br>□ Abnormal, specify _____ |
| Musculoskeletal | □ Normal<br>□ Abnormal, specify _____ |
| Neurological | □ Normal<br>□ Abnormal, specify _____ |
| **Vaccination** | |
| Is the participant eligible to take part of this study? | □ Yes □ No |
| Date of vaccination | _ _ - _ _ - _ _ _ _ (DD/MM/YYYY) |
| Time of vaccination | _ _ : _ _ (HH : MM) |
| Type of vaccine | □ QIV □ TIV |

| **Laboratory result** | |
|---|---|
| Date of sample collection | **_ _ - _ _ - _ _ _ _ (DD/MM/YYYY)** |
| Time of sample collection | **_ _ : _ _ (HH : MM)** |
| A/H1N1 Antibody titer | **1 : _ _**<br>**(antibody titer 1:xx)** |
| A/H3N2 Antibody titer | **1 : _ _**<br>**(antibody titer 1:xx)** |
| B/Yamagata Antibody titer | **1 : _ _**<br>**(antibody titer 1:xx)** |
| **Solicited reactions** | |
| **Did you experience these symptoms within 30 minutes after vaccine injection?** | |
| Pain | □ **Yes** □ **No** |
| Redness | □ **Yes** □ **No** |
| Swelling | □ **Yes** □ **No** |
| Induration | □ **Yes** □ **No** |
| Ecchymosis | □ **Yes** □ **No** |
| Fever | □ **Yes** □ **No** |
| Headache | □ **Yes** □ **No** |
| Malaise | □ **Yes** □ **No** |
| Shivering | □ **Yes** □ **No** |