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new mes... Poetry Artificial Intelligenc... K-12 Schools Requi... "Off-Label" and Inv... 2021-06-22.CBM JE... NCCE 2022: App H... Fundamentals of Im... Other fav


v-safe after vaccination health checker English Sign Out


Home Health Check-ins My Profile

Hello, [REDACTED]

 Have you received an additional dose of the COVID-19 vaccine?

[Enter Vaccine Information](#)

 [View My Profile](#)

 [Add a Dependent](#)

REGISTRANT CODE [REDACTED] DATE OF BIRTH [REDACTED] 1985 MOBILE NUMBER [REDACTED]

Vaccines

Vaccine: Janssen/Johnson & Johnson Dose 1 DATE REPORTED: March 14 2021


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to search

52°F Partly sunny 1:01 PM 5/7/2022

v-safe after vaccination health checker English Sign Out

Home Health Check-ins My Profile

 All set!

You have no pending Health Check-ins.

No Surveys found

Previous Activity

- Final Health Check-in March 14 2022 2:31 pm
- 6 Month Health Check-in September 12 2021 4:49 pm
- 3 Month Health Check-in June 13 2021 5:38 pm
- 42 day Health Check-in April 25 2021 4:14 pm
- Weekly Health Check-in April 18 2021 11:11 pm
- Weekly Health Check-in April 11 2021 5:03 pm
- Weekly Health Check-in April 5 2021 1:31 am
- Weekly Health Check-in March 28 2021 3:04 pm
- Daily Health Check-in March 21 2021 2:47 pm
- Daily Health Check-in March 20 2021 3:54 pm
- Daily Health Check-in March 19 2021 3:49 pm
- Daily Health Check-in March 17 2021 4:22 pm
- Daily Health Check-in March 16 2021 3:42 pm
- Daily Health Check-in March 15 2021 3:54 pm
- Initial Health Check-in March 14 2021 3:22 pm

Initial Health Check-in

Survey Name Initial Health Check-in
Started 14 MAR 2021 22:15
Completed In 6:52 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Since your COVID-19 vaccination, have you had a fever or felt feverish?

Yes
No

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Itching

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain
Rash, not including the immediate area around the injection site
None

Any other symptoms or health conditions you want to report? *About 5 minutes after injection, I got shooting pains down my arm through wrist and up over my shoulder through my neck. My wrist felt weak and limp. My throat and tongue started swelling about 20 minutes after injection. They gave me one 25 mg liquid cap of Diphenhydramine HCl. By 2 hours later, the swelling was entirely gone.*

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

Were you pregnant at the time of your COVID-19 vaccination?

Yes
No
I don't know

What is your ethnic group?

Hispanic or Latino
Not Hispanic or Latino
Unknown or prefer not to say

What is your race?

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
Other
Unknown or prefer not to say

Daily Health Check-in

Survey Name Daily Health Check-In
Started 16 MAR 2021 22:40
Completed in 1:52 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Have you had a fever or felt feverish today?

Yes
No

Do you know your highest temperature reading from today?

Yes - in degrees Fahrenheit
Yes - In degrees Celsius
No - I don't remember the reading
No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). **102.1**

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain
Rash, not including the immediate area around the injection site
None

Any other symptoms or health conditions you want to report **Jaw pain, ear pain, light sensitivity**

Chills

Mild
Moderate
Severe

Headache

Mild
Moderate
Severe

Joint pains

Mild
Moderate
Severe

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Abdominal pain

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other, please describe

Daily Health Check-in

Survey Name Daily Health Check-In
Started 16 MAR 2021 22:50
Completed in 4:1 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Have you had a fever or felt feverish today?

Yes
No

Do you know your highest temperature reading from today?

Yes - in degrees Fahrenheit
Yes - In degrees Celsius
No - I don't remember the reading
No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). **104.8**

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain
Rash, not including the immediate area around the injection site
None

Chills

Mild
Moderate
Severe

Headache

Mild
Moderate
Severe

Joint pains

Mild
Moderate
Severe

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Abdominal pain

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other, please describe

Daily Health Check-in

Survey Name Daily Health Check-in
Started 19 MAR 2021 22:45
Completed In 3:28 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Have you had a fever or felt feverish today?

Yes
No

Do you know your highest temperature reading from today?

Yes - In degrees Fahrenheit
Yes - In degrees Celsius
No - I don't remember the reading
No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). **99.1**

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Itching

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain

Rash, not including the immediate area around the injection site
None
Any other symptoms or health conditions you want to report **Jaw pain, light sensitivity, dizzy**

Headache

Mild
Moderate
Severe

Joint pains

Mild
Moderate
Severe

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other, please describe **They said they may need to schedule a CT or MRI on Monday after an evaluation.**

Daily Health Check-in

Survey Name Daily Health Check-in
Started 17 MAR 2021 23:15
Completed In 7:52 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Have you had a fever or felt feverish today?

Yes
No

Do you know your highest temperature reading from today?

Yes - In degrees Fahrenheit
Yes - In degrees Celsius
No - I don't remember the reading
No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). **101.2**

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Itching

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain

Rash, not including the immediate area around the injection site
None

Any other symptoms or health conditions you want to report **I went to the doctor in person and he said I had brain swelling and toxic reaction. MTHFR double mutation C677T methylation process isn't normal with me. It's been more than 48hrs. It matches the symptoms for toxic exposure for brain swelling including not remembering much since getting home from vaccination on March 14, abnormal heart rhythm and rapid heartbeat, numbness and tingling in arm and fingers, flaccid limbs/arms, impaired balance, dizziness, fever higher than 103 (went up to 104.5), difficulty thinking, reading and writing, neck stiffness, lethargy and non-responsive when family member tried to wake me up.**

Headache

Mild
Moderate
Severe

Joint pains

Mild
Moderate
Severe

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Abdominal pain

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other, please describe

Daily Health Check-in

Survey Name Daily Health Check-in
Started 21 MAR 2021 21:45
Completed in 2:12 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Have you had a fever or felt feverish today?

Yes
No

Do you know your highest temperature reading from today?

Yes - in degrees Fahrenheit
Yes - In degrees Celsius
No - I don't remember the reading
No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). **99.1**

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Itching

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain
Rash, not including the immediate area around the injection site
None
Any other symptoms or health conditions you want to report: **Jaw pain, brain fog, lethargy.**

Headache

Mild
Moderate
Severe

Joint pains

Mild
Moderate
Severe

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional

Daily Health Check-in

Survey Name Daily Health Check-in
Started 20 MAR 2021 22:31
Completed in 3:77 minutes

How are you feeling today?

Good
Fair
Poor

Fever Check

Have you had a fever or felt feverish today?

Yes
No

Do you know your highest temperature reading from today?

Yes - in degrees Fahrenheit
Yes - In degrees Celsius
No - I don't remember the reading
No - I didn't take my temperature

Enter your highest temperature reading from today (degrees Fahrenheit). **100.9**

Symptom Check

Have you had any of these symptoms today where you got the shot (injection site)?

Pain
Redness
Swelling
Itching
None

Pain

Mild
Moderate
Severe

Itching

Mild
Moderate
Severe

Have you experienced any of these symptoms today?

Chills
Headache
Joint pains
Muscle or body aches
Fatigue or tiredness
Nausea
Vomiting
Diarrhea
Abdominal pain
Rash, not including the immediate area around the injection site
None
Any other symptoms or health conditions you want to report: **Jaw pain severe enough it's hard to open my mouth to eat, dizziness, lethargy, legs buckle when trying to walk, neck pain and stiffness, brain fog.**

Headache

Mild
Moderate
Severe

Joint pains

Mild
Moderate
Severe

Muscle or body aches

Mild
Moderate
Severe

Fatigue or tiredness

Mild
Moderate
Severe

Health Impact

Did any of the symptoms or health conditions you reported today cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other, please describe: **Telehealth with scheduled appointment on Monday -nurses keep asking if I've received a call from CDC based on severity and duration of fever and symptoms.**

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 28 MAR 2021 22:01

Completed In 3.05 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Chest pain through last night when inhaling, hypotension (90/52) and high resting heart rate (96).

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 05 APR 2021 08:23

Completed In 8.62 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Nausea, vomiting, ER visit, + x2 urgent care & 4/4/21, 2 chest x-ray, EKG, referral to cardiologist & immunology, continued symptoms & 100 bpm resting hr & more chest pain. No underlying health conditions. MRI 4/14/21. Dr.no work thru 4/12. Help me!

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 12 APR 2021 00:00

Completed In 2.68 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Infectious disease expert is going to test for blood clots, send me for CTA scan, MRI is scheduled for April 14, Neurologist April 16.

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Weekly Health Check-in

Survey Name Weekly Health Check-in

Started 19 APR 2021 06:03

Completed In 7.58 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Aphasia, leg pain, continued back ache, severe headache, MRI and Venogram. Venous flow signal in left transverse and sigmoid sinus, small & irregular. Arachnoid granulation. 2013 MRI showed symmetry and all normal scan in contrast. Please help me!

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

42 day Health Check-in

Survey Name	42 day Health Check-in
Started	25 APR 2021 23:08
Completed In	6.32 minutes

How are you feeling today?

Good

Fair

Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Drops in blood pressure (85/52 & 100bpm resting her) Chest pain, racing heart, blurry vision, headache, dizziness, back pain, difficulty with speech, reading, writing walking, MD said symptoms like TIAs, and TBI, referral for neuro-rehab, physical th

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe | PCP & Neurologists referrals declined by specialist as they say they don't have capacity to work with people with reaction after Covid-19 vaccination

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

How would you describe your current state of health?

Excellent

Good

Fair

Poor

How is your health now compared to your health before your last COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

3 Month Health Check-in

Survey Name	3 Month Health Check-in
Started	14 JUN 2021 00:30
Completed In	8.1 minutes

How are you feeling today?

Good

Fair

Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Doubled over abdominal pain, blurry vision, cold sweat, leg pain Ringing in my ear, VOR dysfunction. Ongoing speech therapy, vestibular & physical therapy. All test: no underlying conditions. Next test: Transcranial Doppler (June 21).

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe Ongoing testing. Echocardiogram, Zio patch, EMG, hearing test, VNG, transcranial Doppler, EEG, allergist testing in July for polysorbate 80, still on full disability, not medically cleared to drive, not cleared to walk more than 25 minutes a day

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

How is your health now compared to before your COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

6 Month Health Check-in

Survey Name	6 Month Health Check-in
Started	12 SEP 2021 23:42
Completed In	6.57 minutes

How are you feeling today?

Good

Fair

Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Confirmed elevated sCD40L & CC5L, diagnosed platelet activation, vascular inflammation, encephalopathy still full disability, not medically cleared to drive. Negative nucleocapsid test, 6 months of testing confirming no underlying health conditions.

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe 100+ days of speech, physical therapy and vestibular therapy & more to come; still no help from CISA after 6 months of trying, still no response from CDC, no help from public health, no help from FDA, needs to be moved under NVICP

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

How is your health now compared to before your COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

Final Health Check-in

Survey Name	Final Health Check-in
Started	14 MAR 2022 21:20
Completed In	11.05 minutes

How are you feeling today?

Good

Fair

Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes

No

Please describe the symptoms or health conditions.

Elevated sCD40L, VEGF (seen in hypoxia & thrombocytopenia), fusion with defective saccades, light & sound sensitivity, dizziness, "presents like TBI," speech therapy, vision rehabilitation, debilitating fatigmenstural clotting

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school

Be unable to do your normal daily activities

Get care from a doctor or other healthcare professional

None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation

Outpatient clinic or urgent care clinic visit

Emergency room or emergency department visit

Hospitalization

Other - please describe Speech therapy, osteopathic rehabilitation, neural-vision rehabilitation, vestibular therapy, 9 research studies, including specialist labs. Found S1 in non-classical monocytes 6 months post injection with negative nucleocapsid and negative PCR

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes

No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes

No

How is your health now compared to before your COVID-19 vaccination?

Better

About the same

Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes

No

[REDACTED]

First Health Check-In: March 14, 2021

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] time the notification to complete health screening and did not reflect highest of the day or night.

CDC Called on September 29, 2021 from an unmarked call listed as “scam likely” asking “when did you recover” despite my most recent report on September 12, 2021 (6 month Health Check) stating I was unrecovered, my health was worse than before vaccination and believed the health problems were related to COVID-19 vaccination.

How are you feeling today?

Good
Fair
Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes
No

Please describe the symptoms or health conditions.

Confirmed elevated sCD40L & CCSL, diagnosed platelet activation, vascular inflammation, encephalopathy still full disability, not medically cleared to drive. Negative nucleocapsid test, 6 months of testing confirming no underlying health conditions.

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit

How is your health now compared to before your COVID-19 vaccination?

Better
About the same
Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes
No

Note that the character limits prevented me from including all symptoms, specialists, diagnoses, and treatment. The options were so limited, all other symptoms needed to be documented in free-response, but not enough character space requiring omission of symptoms and medical visits. For example, physical therapy was cut off and could not write any more. This alone is limiting safety signals.

42 day Health Check-in

Survey Name	42 day Health Check-in
Started	25 APR 2021 23:08
Completed In	6.32 minutes

How are you feeling today?

Good
Fair
Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes
No

Please describe the symptoms or health conditions.

Drops in blood pressure (85/52 & 100bpm resting her) Chest pain, racing heart, blurry vision, headache, dizziness, back pain, difficulty with speech, reading, writing walking, MD said symptoms like TIAs, and TBI, referral for neuro-rehab, physical th

This should have been an immediate cause for concern on April 19, 2021 considering the emergency call for clinicians on the blood clots with CVST: [Webinar April 15, 2021 - Johnson & Johnson/Janssen COVID-19 Vaccine and Cerebral Venous Sinus Thrombosis with Thrombocytopenia – Update for Clinicians on Early Detection and Treatment \(cdc.gov\)](#). Venous flow signal in left transverse and sigmoid sinus note and “Please help me!” on April 19, 2021

Started	19 APR 2021 06:03
Completed In	7.58 minutes

How are you feeling today?

Good
Fair
Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes
No

Please describe the symptoms or health conditions.

Aphasia, leg pain, continued back ache, severe headache, MRI and Venogram. Venous flow signal in left transverse and sigmoid sinus, small & irregular. Arachnoid granulation. 2013 MRI showed symmetry and all normal scan in contrast. Please help me!