Supplementary material 1. General Inquiries and Demographic Information

Questions	Answers		
Gender	Male ☐	Female ☐	
Age			
Height (cm)			
Weight (kg)			
Level of education			
General health	Very good-excellent ☐	Fair-good ☐	Poor ☐
Chronic illness If yes, please add all that apply if you have any of the following health conditions (Diabetes, Hypertension, Chronic lung disease, Chronic kidney disease, Dyslipidemia, An immunosuppressive disease or on long term immunosuppressive medications).	Yes ☐ ☐	No ☐	
Smoking	Yes ☐	No ☐	
Pre-existing cardiovascular conditions (Coronary artery stenting or a history of cardiac surgery with bypass grafts or a history of myocardial infarction or cardiac are unit (CCU) admission due to acute coronary syndrome or diagnosed as chronic coronary syndrome.)	Yes ☐	No ☐	

Supplementary material 2. Questions to assess oral health condition:

Questions	Answers			
1. How many times do you brush your teeth?	No brushing (0)	Once a day (1)	Twice or more a day (2)	
2. How do you clean your teeth?	Toothbrush, fluoride toothpaste & dental floss (3)	Toothbrush, fluoride toothpaste (2)	Toothbrush only (1)	
3. How often do you change your toothbrush?	Once in 3 months (2)	Once in 6 months or more (0)		
4. Do you use mouthwashes containing fluoride?	Often (2)	Sometimes (1)	Rare or never (0)	
5. Do you complain of halitosis (bad smell from your mouth)?	Often (0)	Sometimes (1)	Rare or never (2)	
6. Do you complain of bleeding on brushing or gingival bleeding?	Often (0)	Sometimes (1)	Rare or never (2)	
7. Do you suffer from teeth sensitivity?	Often (0)	Sometimes (1)	Rare or never (2)	
8. Do you have toothaches?	Yes (0)	No (2)		
9. How often do you eat sugar?	Daily (0)	Weekly or more (2)		
10. Do you consume sugar-rich drinks?	Often (0)	Rare (2)		
11. How often do you visit the dental clinic for a check-up?	Once a year or more often (2)	Once every few years or when there is pain (0)		
12. What procedures do you do the most?	Scaling (2)	Restorations (1)	Extraction (0)	
13. How often do you get your teeth cleaned by a dentist?	Rare or never (0)	Once in a year (1)	Twice in a year (2)	
14. Are there restorations in your teeth?	No cavities at all (2)	1-2 cavities (1)	3 cavities or more (0)	Don’t know (0)
15. Do you have any unrestored/decayed teeth?	Yes (0)	No (2)		
16. Do you have mobile teeth?	Yes (0)	No (2)	Don’t know (2)	
17. State your dental condition.	Contain missing teeth (0)	Contain missing teeth restored with fixed or removable prosthesis (1)	Contain no missing teeth (2)	
18. How were your oral hygiene measures during being infected with COVID-19?	Increased (2)	Decreased (0)	The same (1)	

Supplementary material 3. Questions to evaluate the seriousness of COVID-19 illness:

Questions	Answers		
1. Did you test PCR positive for COVID-19?	Yes	No	
2. Did you complain of fever?	Yes	No	
3. Did you complain of a cough?	Yes	No	
4. Did you complain of a sore throat?	Yes	No	
5. Did you complain of malaise?	Yes	No	
6. Did you complain of a headache?	Yes	No	
7. Did you complain of diarrhoea?	Yes	No	
8. Did you complain of loss of taste &/or smell sensation?	Yes	No	
9. Did you complain of muscle pain?	Yes	No	
10. Did you experience dyspnea or shortness of breath?	Yes	No	Not sure
11. Did you do a chest X-ray or CT chest?	Yes	No	
12. Did your chest X-ray or CT show pneumonia?	Yes	No	Don't know
13. When did you start to feel better?	After a week or less	After 1-2 weeks	other
14. When did your symptoms start to disappear?	After a week or less	After 1-2 weeks	other
15. When did you feel free of symptoms (fully recovered)?	2 weeks	4 weeks	6 weeks
16. Did you need hospitalization?	Yes	No	
17. Did you experience high-grade fever >39?	Yes	No	
18. Did you experience severe dyspnea with cyanosis?	Yes	No	Not sure
19. Did you experience chest pain?	Yes	No	
20. Did you experience an increase in respiratory rate?	Yes	No	Not sure
21. Did you experience an increase in heart rate?	Yes	No	Not sure
22. Did you experience a decrease in blood pressure?	Yes	No	Not sure
23. Did your condition require entering the intensive care unit?	Yes	No	
24. Did your condition require a ventilator?	Yes	No	