

| <b>ECHO</b><br>Environmental influences<br>on Child Health Outcomes<br>A program supported by the NIH | <b>COVID-19 Questionnaire – Adult Primary Version</b><br>ECHO-wide Cohort Version 01.30 / April 9, 2020 |  |                |  | <b>Form C19-aPV</b><br>Page 1 of 9      |  |
|---|---|--|----------------|--|---|--|
|   | COHORT ID   | SITE ID  | PARTICIPANT ID | PIN  | COHORT VISIT ID                         | FORM COMPLETED   |
| _____   | _____   | _____  | _____          | _____  | ____ / ____ / ____<br><i>mm dd yyyy</i> |  |
| ECHO LIFE STAGE   |   |  | RESPONDENT     |  |   |  |
| <input type="checkbox"/> <sub>01</sub> Prenatal   |   | <input type="checkbox"/> <sub>02</sub> Perinatal       |                | <input type="checkbox"/> <sub>01</sub> Participant       |   | <input type="checkbox"/> <sub>02</sub> Biological Mother |
| <input type="checkbox"/> <sub>03</sub> Infancy  |   | <input type="checkbox"/> <sub>04</sub> Early Childhood |                | <input type="checkbox"/> <sub>03</sub> Biological Father |   | <input type="checkbox"/> <sub>04</sub> Other Respondent  |
| <input type="checkbox"/> <sub>05</sub> Middle Childhood   |   | <input type="checkbox"/> <sub>06</sub> Adolescence     |                | Code: ____   |   |  |

**STUDY STAFF INSTRUCTION:** This form should be completed by the pregnant woman enrolled in an ECHO cohort during the prenatal life stage and by the primary caregiver of a child enrolled in an ECHO cohort during the infancy, early childhood, middle childhood, and adolescence life stages. In the prenatal life stage, the pregnant woman’s ID should be used in the header for the participant ID. In all other life stages, the child’s ID should be used in the header for the participant ID.

**INSTRUCTIONS:**

*This form has 4 sections:*

- *Section A: COVID-19 Infection*
- *Section B: Impacts of the COVID-19 Outbreak on You*
- *Section C: Impacts of the COVID-19 Outbreak on Pregnancy – Current*
- *Section D: Impacts of the COVID-19 Outbreak on Pregnancy – Recall*

*Please complete Sections A and B. If you enrolled in ECHO during pregnancy and are currently pregnant, please also complete Section C. If you enrolled in ECHO during pregnancy and the pregnancy ended after February 28, 2020, please also complete Section D.*

*These questions are about your experience with COVID-19, or the coronavirus. For each question, do the best you can to remember the details requested.*



**Section A. COVID-19 Infection**

For the following questions, healthcare provider means a doctor, nurse practitioner, physician assistant or anyone you go to for medical care.

1. Has a healthcare provider ever told you that you have, or likely have, COVID-19 (Coronavirus)?

<sub>01</sub> Yes

<sub>02</sub> No

2. Which of the following symptoms have you had at any point in time since March 1, 2020? (**Mark all that apply**)

<sub>01</sub> Fever or chills

<sub>02</sub> Cough

<sub>03</sub> Shortness of breath

<sub>04</sub> Sore throat

<sub>05</sub> Headache

<sub>06</sub> Muscle or body aches

<sub>07</sub> Runny nose

<sub>08</sub> Fatigue or excessive sleepiness

<sub>09</sub> Diarrhea, nausea, or vomiting

<sub>10</sub> Loss of sense of smell or taste

<sub>11</sub> Itchy/red eyes

<sub>12</sub> None of the above → **skip to Section A, Question 3.**

2.a. Which of the following occurred as a result of your symptoms? (**Mark all that apply**)

<sub>01</sub> I was kept overnight in a hospital because a healthcare provider thought I had COVID-19

<sub>02</sub> I saw a healthcare provider in person, such as in a clinic, doctor's office, urgent care, or Emergency Room (ER)/Emergency Department (ED)

<sub>03</sub> I spoke to a healthcare provider over the phone, by email, or online

<sub>04</sub> I self-isolated or quarantined at home

<sub>05</sub> None of the above

2.b. In the two weeks before you had symptoms, did you: (**Mark all that apply**)

<sub>01</sub> Have contact with someone who tested positive for COVID-19

<sub>02</sub> Have contact with someone who likely had COVID-19 (e.g., was not tested but had symptoms; was told by a healthcare provider that he/she likely had it)

<sub>03</sub> Travel to a different state or country (please specify: \_\_\_\_\_)

<sub>04</sub> None of the above



**Section A. COVID-19 Infection (continued)**

3. Have you had the nose swab test for the virus that causes COVID-19? (**Mark all that apply**)

- <sub>01</sub> No, I never tried to get tested
- <sub>02</sub> No, I tried to get tested but was not able to
- <sub>03</sub> Yes, and I am waiting for the results

**If yes → 3.a.** When was the date of your most recent test?      /      /       
*mm* *yyyy*

- <sub>04</sub> Yes, and the test showed that I do not have it (“**negative**” test)

**If yes → 3.b.** When was the date of your most recent **negative** test?      /      /       
*mm* *yyyy*

- <sub>05</sub> Yes, and the test showed that I do have it (“**positive**” test)

**If yes → 3.c.** When was the date of your most recent **positive** test?      /      /       
*mm* *yyyy*

4. Have you had a blood test to see whether you already had the COVID-19 virus (“serology”)? (**Mark all that apply**)

- <sub>01</sub> No, I never tried to get tested
- <sub>02</sub> No, I tried to get tested but was not able to
- <sub>03</sub> Yes, and I am waiting for the results

**If yes → 4.a.** When was the date of your most recent test?      /      /       
*mm* *yyyy*

- <sub>04</sub> Yes, and the test showed that I did not have it (“**negative**” test)

**If yes → 4.b.** When was the date of your most recent **negative** test?      /      /       
*mm* *yyyy*

- <sub>05</sub> Yes, and the test showed that I did have it (“**positive**” test)

**If yes → 4.c.** When was the date of your **positive** test?      /      /       
*mm* *yyyy*

5. Has anyone else living in your home had, or probably had, COVID-19?

- <sub>01</sub> Yes
- <sub>02</sub> No

| Setting  | Mode   |
|--|--|
| <input type="checkbox"/> <sub>01</sub> Clinic or site <input type="checkbox"/> <sub>02</sub> Phone <input type="checkbox"/> <sub>03</sub> Other location | <input type="checkbox"/> <sub>01</sub> Self-administered <input type="checkbox"/> <sub>02</sub> Staff-administered |