COVID-19 Questionnaire

Participant ID #: ☐☐☐☐☐☐☐ Acrostic: ☐☐☐☐☐☐☐☐

Interviewer ID: ☐☐☐☐☐☐ Date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

interviewer covid_dt

Introduction

To help us understand the health of study participants during the COVID-19 pandemic, we would like to ask you additional questions about your possible exposure to this new virus.

The interview may take as little as 5 minutes, or as much as 30 minutes, depending on whether or not you have been diagnosed with COVID-19.

This information will be handled in the same way as the other data we have collected by phone. If you'd like, I can review that information with you now. (Review initial phone consent if participant says they need it).

Who is completing the survey: Participant or Proxy? proxy

- ○ 1 Participant
- ○ 2 Proxy

Would it be okay to ask you questions about COVID-19 related experiences today? oktoask

- ○ 1 "Yes - okay to ask"
- ○ 0 "No - not okay to ask"

In the future, may we call you again to see how you're doing and ask you these questions again? okfuture

- ○ 1 "Yes - okay to call again"
- ○ 0 "No - do not call again"

COVID-19 DIAGNOSIS

1. Have you had COVID-19, or the illness caused by the novel coronavirus? hadcovid1

- ○ 1 Yes, definitely
- ○ 2 Yes, I think so
- ○ 3 Maybe
- ○ 0 No

Red text: Variable/field names

Red numbers: When responses are coded as numeric values, corresponding numbers are displayed.

2. Has a healthcare provider ever told you that you had COVID-19? hadcovid2

- ○ 1 Yes, definitely →
- ○ 2 Yes, probably or suspected →
- ○ 0 No

If yes, did you have:

a. Symptoms of COVID-19 ○ 1 Yes ○ 0 No hadcovid2a

b. A positive test for COVID-19 ○ 1 Yes ○ 0 No hadcovid2a_b

c. Close contact with someone who had COVID-19 ○ 1 Yes ○ 0 No hadcovid2b

For ascertainment of medical records:

Name of doctor/clinic/hospital: ascert1_1

Address of doctor/clinic/hospital: ascert1_2

Contact number: ascert1_4

3. Have you been tested for coronavirus or COVID-19? tested

- ○ 1 Yes →
- ○ 0 No
- ○ 2 Unsure

If yes, have you ever had a test for:

a. COVID-19 infection? ○ 1 Yes ○ 0 No tested_a

→ Result: ○ 1 Positive ○ 2 Negative ○ 3 Pending tested_a_y

b. COVID-19 immunity? ○ 1 Yes ○ 0 No tested_b

→ Result: ○ 1 Positive ○ 2 Negative ○ 3 Pending tested_b_y

c. How many times have you been tested? tested_c

d. Can you provide details regarding your first COVID-19 test? tested_d

i. Date: tested_d_i

ii. Reason for testing: tested_d_ii

	Yes 1	No 0	
1. I had symptoms of COVID-19	○	○	tested_d_ii_1
2. Someone I know had symptoms of COVID-19	○	○	tested_d_ii_2
3. A doctor told me to be tested for COVID-19	○	○	tested_d_ii_3
4. I was worried about COVID-19	○	○	tested_d_ii_4
5. Other	○	○	tested_d_ii_5

→ Specify 'Other': tested_d_ii_oth

(continued)

(continued)

iii. Type of test: tested_d_iii

		Yes 1	No 0
1. Nasopharyngeal swab	tested_d_iii_1	○	○
2. Blood test	tested_d_iii_2	○	○
3. Saliva test	tested_d_iii_3	○	○
4. Other	tested_d_iii_4	○	○

↳ Specify 'Other': tested_d_iii_oth

iv. Result: tested_d_iv

○ 1 Positive

○ 2 Negative

○ 3 Unsure/Pending

e. Can you provide details regarding your most recent COVID-19 test? tested_e

i. Date: tested_e_i

ii. Reason for testing:

		Yes 1	No 0
tested_e_ii_1	1. I had symptoms of COVID-19	○	○
tested_e_ii_2	2. Someone I know had symptoms of COVID-19	○	○
tested_e_ii_3	3. A doctor told me to be tested for COVID-19	○	○
tested_e_ii_4	4. I was worried about COVID-19	○	○
tested_e_ii_5	5. Other	○	○

↳ Specify 'Other': tested_e_ii_oth

iii. Type of test: tested_e_iii

		Yes 1	No 0
1. Nasopharyngeal swab	tested_e_iii_1	○	○
2. Blood test	tested_e_iii_2	○	○
3. Saliva test	tested_e_iii_3	○	○
4. Other	tested_e_iii_4	○	○

↳ Specify 'Other': tested_e_iii_oth

iv. Result: tested_e_iv

○ 1 Positive

○ 2 Negative

○ 3 Unsure/Pending

(continued)

(continued)

f. *If you did not experience a positive result on your first or most recent test,* have you ever had a positive COVID-19 test? tested_f

○1 Yes

○0 No

○2 Unsure

i. If yes, can you provide details on your first positive COVID-19 test? tested_f_y

1. Date: tested_f_i

2. Reason for testing: tested_f_ii

		Yes 1	No 0
tested_f_ii_1	a. I had symptoms of COVID-19	○	○
tested_f_ii_2	b. Someone I know had symptoms of COVID-19	○	○
tested_f_ii_3	c. A doctor told me to be tested for COVID-19	○	○
tested_f_ii_4	d. I was worried about COVID-19	○	○
tested_f_ii_5	e. Other	○	○

↳ Specify 'Other': tested_f_ii_oth

3. Type of test: tested_f_iii

		Yes 1	No 0
a. Nasopharyngeal swab	tested_f_iii_1	○	○
b. Blood test	tested_f_iii_2	○	○
c. Saliva test	tested_f_iii_3	○	○
d. Other	tested_f_iii_4	○	○

↳ Specify 'Other': tested_f_iii_oth

g. Are you willing and able to send a copy of your COVID-19 results to the study? test_reslt_g

○1 Yes

○0 No

4. Have you had any x-ray or computed tomography ("cat") scans for suspected or diagnosed COVID-19? xray_cat_yn

○1 Yes ⟶

○0 No

If yes:

		Yes 1	No 0
xray_cat_a	a. Did you have a chest X-ray?	○	○
xray_cat_b	b. Did you have a CT scan of your lungs?	○	○
xray_cat_c	c. Are you willing to have your lung images shared with the study?	○	○

5. Have you ever had an overnight stay in a hospital for suspected or diagnosed COVID-19? hosp_yn

○ 1 Yes ⟶

○ 0 No

If yes:

a. How many nights were you in the hospital? hosp_a

i. Date arrived at hospital: ___hosp_a_i___

ii. Date discharged from hospital: hosp_a_ii

b. Did you require any of the following treatments? hosp_b

		Yes 1	No 0	# Days
i. Oxygen by nasal canula (in your nose)	hosp_b_i	○	○	hosp_b_i_days
ii. Oxygen by face mask	hosp_b_ii	○	○	hosp_b_ii_days
iii. "Intensive care unit" or ICU monitoring	hosp_b_iii	○	○	hosp_b_iii_days
iv. A breathing tube or ventilator	hosp_b_iv	○	○	hosp_b_iv_days
v. "ECMO" treatment	hosp_b_v	○	○	hosp_b_v_days

For ascertainment of medical records:

Name of doctor/clinic/hospital: ascert2_1

Address of doctor/clinic/hospital: ascert2_2

Contact number: ascert2_3

6. If you were hospitalized for suspected or diagnosed COVID-19, how were you discharged? hosp_6

		Yes 1	No 0
a. Home	hosp_6a	○	○
b. Nursing facility	hosp_6b	○	○
c. Other	hosp_6c	○	○

↳ Specify 'Other': hosp_6c_oth

7. If you know, or believe, that you had COVID-19: have you recovered to your usual state of health? recovd_7

○ 1 Yes ⟶

○ 0 No

If yes:

a. How long did it take for you to recover? recovd_7_hl days

If yes to Q7:

For participants who have recovered from symptoms related to COVID-19 illness:

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health? recov_a	B. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5? (1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = quite a bit, 5 = very much)	C. How long, in days, did the symptom last?
Fever recov_a1	○1 Yes ○0 No	recov_b1 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c1
Trouble breathing recov_a2	○1 Yes ○0 No	recov_b2 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c2
Chest congestion recov_a3	○1 Yes ○0 No	recov_b3 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c3
Chest tightness recov_a4	○1 Yes ○0 No	recov_b4 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c4
Dry or hacking cough recov_a5	○1 Yes ○0 No	recov_b5 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c5
Wet or loose cough recov_a6	○1 Yes ○0 No	recov_b6 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c6
Body aches or pains recov_a7	○1 Yes ○0 No	recov_b7 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c7
Chills or shivering recov_a8	○1 Yes ○0 No	recov_b8 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c8
Sore or painful throat recov_a9	○1 Yes ○0 No	recov_b9 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c9
Congested or stuffy nose recov_a10	○1 Yes ○0 No	recov_b10 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c10
Runny or dripping nose recov_a11	○1 Yes ○0 No	recov_b11 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c11
Diarrhea recov_a12	○1 Yes ○0 No	recov_b12 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c12
Weak or tired recov_a13	○1 Yes ○0 No	recov_b13 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c13
Loss of smell recov_a14	○1 Yes ○0 No	recov_b14 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c14
Loss of taste recov_a15	○1 Yes ○0 No	recov_b15 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	recov_c15

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument) recov_overall_1

○ Mild 1 ○ Moderate 2 ○ Severe 3 ○ Very Severe 4

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities) recov_overall_2

○1 Not at all ○2 A little bit ○3 Somewhat ○4 Quite a bit ○5 Very much

Skip to question 9

If no to Q7:

For participants who continue to have symptoms related to COVID-19 illness: notrecovd

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health? notrecov_a	B. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5? (1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = quite a bit, 5 = very much)	C. How long, in days, has this symptom bothered you?
Fever notrecov_a1	○ 1 Yes ○ 0 No	notrecov_b1 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c1
Trouble breathing notrecov_a2	○ 1 Yes ○ 0 No	notrecov_b2 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c2
Chest congestion notrecov_a3	○ 1 Yes ○ 0 No	notrecov_b3 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c3
Chest tightness notrecov_a4	○ 1 Yes ○ 0 No	notrecov_b4 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c4
Dry or hacking cough notrecov_a5	○ 1 Yes ○ 0 No	notrecov_b5 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c5
Wet or loose cough notrecov_a6	○ 1 Yes ○ 0 No	notrecov_b6 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c6
Body aches or pains notrecov_a7	○ 1 Yes ○ 0 No	notrecov_b7 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c7
Chills or shivering notrecov_a8	○ 1 Yes ○ 0 No	notrecov_b8 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c8
Sore or painful throat notrecov_a9	○ 1 Yes ○ 0 No	notrecov_b9 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c9
Congested or stuffy nose notrecov_a10	○ 1 Yes ○ 0 No	notrecov_b10 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c10
Runny or dripping nose notrecov_a11	○ 1 Yes ○ 0 No	notrecov_b11 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c11
Diarrhea notrecov_a12	○ 1 Yes ○ 0 No	notrecov_b12 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c12
Weak or tired notrecov_a13	○ 1 Yes ○ 0 No	notrecov_b13 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c13
Loss of smell notrecov_a14	○ 1 Yes ○ 0 No	notrecov_b14 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c14
Loss of taste notrecov_a15	○ 1 Yes ○ 0 No	notrecov_b15 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notrecov_c15

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument) notrecov_overall_1

○ 1 Mild ○ 2 Moderate ○ 3 Severe ○ 4 Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities) notrecov_overall_2

○ 1 Not at all ○ 2 A little bit ○ 3 Somewhat ○ 4 Quite a bit ○ 5 Very much

8. If you have not had diagnosed or suspected COVID-19 illness, have you had any of the following symptoms since our last call?

For participants who do not report diagnosed or suspected COVID-19:

	A. Have you experienced worsening of this symptom compared to your usual state of health? notdiag_a	B. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5? (1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = quite a bit, 5 = very much)	C. How long, in days, did the symptom last?
Fever notdiag_a1	○1 Yes ○0 No	notdiag_b1 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c1
Trouble breathing notdiag_a2	○1 Yes ○0 No	notdiag_b2 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c2
Chest congestion notdiag_a3	○1 Yes ○0 No	notdiag_b3 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c3
Chest tightness notdiag_a4	○1 Yes ○0 No	notdiag_b4 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c4
Dry or hacking cough notdiag_a5	○1 Yes ○0 No	notdiag_b5 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c5
Wet or loose cough notdiag_a6	○1 Yes ○0 No	notdiag_b6 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c6
Body aches or pains notdiag_a7	○1 Yes ○0 No	notdiag_b7 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c7
Chills or shivering notdiag_a8	○1 Yes ○0 No	notdiag_b8 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c8
Sore or painful throat notdiag_a9	○1 Yes ○0 No	notdiag_b9 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c9
Congested or stuffy nose notdiag_a10	○1 Yes ○0 No	notdiag_b10 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c10
Runny or dripping nose notdiag_a11	○1 Yes ○0 No	notdiag_b11 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c11
Diarrhea notdiag_a12	○1 Yes ○0 No	notdiag_b12 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c12
Weak or tired notdiag_a13	○1 Yes ○0 No	notdiag_b13 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c13
Loss of smell notdiag_a14	○1 Yes ○0 No	notdiag_b14 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c14
Loss of taste notdiag_a15	○1 Yes ○0 No	notdiag_b15 1, 1 | 2, 2 | 3, 3 | 4, 4 | 5, 5	notdiag_c15

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument) notdiag_overall_1

○1 Mild ○2 Moderate ○3 Severe ○4 Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities) notdiag_overall_2

○1 Not at all ○2 A little bit ○3 Somewhat ○4 Quite a bit ○5 Very much

9. If you had any of the symptoms we talked about, did you take any medicines? meds_yn

○ 1 Yes

○ 0 No

If yes:

Medicine	Did you take it? Take1 – Take 8	Was is prescribed by health care profes-sional? Prescr1—Pescr8	What was the date when you started to take it?	What was the total number of days that you took it?	What was the specific name of the medication(s)?
Acetaminophen, Tylenol	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt1	ttldays1	specname1
Ibuprofen, Motrin, Advil, Aleve	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt2	ttldays2	specname2
Cough medicine, Robitussin	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt3	ttldays3	specname3
"Cold and Flu" medicine	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt4	ttldays4	specname4
Antibiotic (e.g., azithromycin, augmentin, ciprofloxacin)	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt5	ttldays5	specname5
Oral corticosteroids (e.g., prednisone, prednisolone, methylprednisone)	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt6	ttldays6	specname6
Inhaled corticosteroids (e.g., flovent, symbicort, Advair)	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt7	ttldays7	specname7
Other medicines	○ 1 Yes ○ 0 No	○ 1 Yes ○ 0 No	startdt8	ttldays8	specname8

10. Has anyone in your household (or, the place you are residing) been tested for COVID-19? hh_test_yn

- ○ 1 Yes →
- ○ 0 No
- ○ 2 Unsure

If yes:

a. When was the first test conducted? hh_test_when

b. What was the result of the first test? hh_test_reslt

- ○ 1 Positive
- ○ 2 Negative
- ○ 3 Unsure

Was there a second test? hh_test_yn2

- ○ 1 Yes →
- ○ 0 No

If yes:

a. When was the second test conducted? hh_test_when2

b. What was the result of the second test? hh_test_reslt2

- ○ 1 Positive
- ○ 2 Negative
- ○ 3 Unsure

Was there a third test? hh_test_yn3

- ○ 1 Yes →
- ○ 0 No

If yes:

a. When was the third test conducted? hh_test_when3

b. What was the result of the third test? hh_test_reslt3

- ○ 1 Positive
- ○ 2 Negative
- ○ 3 Unsure

Was there a fourth test? hh_test_yn4

- ○ 1 Yes →
- ○ 0 No

If yes:

a. When was the fourth test conducted? hh_test_when4

b. What was the result of that test? hh_test_reslt4

- ○ 1 Positive
- ○ 2 Negative
- ○ 3 Unsure

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If any of the tests were positive:

Did you change your behavior at home? hh_test_pos

○1 Yes →

○0 No

	Yes 1	No 0
Did you wear a mask at home? hh_test_2a	○	○
Did the infected person(s) wear a mask at home? hh_test_2b	○	○
Did the infected person(s) stay away from you? hh_test_2c	○	○

11. What actions have you taken to reduce your risk of exposure to COVID-19? rrisk

	Yes 1	No 0	
a. Washing hands and/or using sanitizer frequently	○	○	rrisk_a
b. Staying at least 6 feet away from others	○	○	rrisk_b
c. Avoiding large gatherings	○	○	rrisk_c
d. Not going out to restaurants or bars	○	○	rrisk_d
e. Cancelled planned travel	○	○	rrisk_e
f. Wearing a face mask	○	○	rrisk_f
g. Not shaking hands or touching people	○	○	rrisk_g
h. Staying home when I am sick	○	○	rrisk_h
i. Not going to work	○	○	or ○2 Not applicable rrisk_i
j. Wiping down surfaces with disinfectant	○	○	rrisk_j
k. Following government guidelines or rules to stay at home and limiting contacts with other people	○	○	rrisk_k
l. Placed under full quarantine by local authorities	○	○	rrisk_l

12. Do you currently use any tobacco products? tob

	Yes 1	No 0
a. Cigarettes tob_a	○	○
→ Cigarettes per day: tob_a_cigday _____		
b. Pipes tob_b	○	○
c. Cigars tob_c	○	○
d. E-cigarettes tob_d	○	○
e. Other tob_e	○	○
→ Specify 'Other': tob_e_oth _____		

13. Did you receive vaccination for influenza ("the flu shot") between September 2019 and March 2020? fluvacc

- ○ 1 Yes
- ○ 0 No

14. Have you had a test for influenza since January 2020? flutest_2020

- ○ 1 Yes →
- ○ 0 No

If yes:

a. What was the result of the flu test? flutest_2020_a

- ○ 1 Positive
- ○ 2 Negative

b. Was this test performed at the same time as a COVID-19 test? flutest_2020_b

- ○ 1 Yes
- ○ 0 No