COVID-19 Questionnaire

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

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

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?

- ○ Participant
- ○ Proxy

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

- ○ "Yes - okay to ask"
- ○ "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?

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

COVID-19 DIAGNOSIS

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

- ○ Yes, definitely
- ○ Yes, I think so
- ○ Maybe
- ○ No

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

- ○ Yes, definitely →
- ○ Yes, probably or suspected →
- ○ No

If yes, did you have:

a. Symptoms of COVID-19 ○ Yes ○ No

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

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

For ascertainment of medical records:

Name of doctor/clinic/hospital: _____

Address of doctor/clinic/hospital: _____

_____

Contact number: _____

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

- ○ Yes →
- ○ No
- ○ Unsure

If yes, have you ever had a test for:

a. COVID-19 infection? ○ Yes ○ No

↳ Result: ○ Positive ○ Negative ○ Pending

b. COVID-19 immunity? ○ Yes ○ No

↳ Result: ○ Positive ○ Negative ○ Pending

c. How many times have you been tested? _____

d. Can you provide details regarding your <u>first</u> COVID-19 test?

i. Date: _____

ii. Reason for testing:

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

↳ Specify 'Other': _____

(continued)

(continued)

iii. Type of test:

	Yes	No
1. Nasopharyngeal swab	○	○
2. Blood test	○	○
3. Saliva test	○	○
4. Other	○	○

↳ Specify 'Other': _____

iv. Result:

- ○ Positive
- ○ Negative
- ○ Unsure/Pending

e. Can you provide details regarding your <u>most recent</u> COVID-19 test?

i. Date: _____

ii. Reason for testing:

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

↳ Specify 'Other': _____

iii. Type of test:

	Yes	No
1. Nasopharyngeal swab	○	○
2. Blood test	○	○
3. Saliva test	○	○
4. Other	○	○

↳ Specify 'Other': _____

iv. Result:

- ○ Positive
- ○ Negative
- ○ 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?

- ○ Yes
- ○ No
- ○ Unsure

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

1. Date: _____

2. Reason for testing:

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

↳ Specify 'Other': _____

3. Type of test:

	Yes	No
a. Nasopharyngeal swab	○	○
b. Blood test	○	○
c. Saliva test	○	○
d. Other	○	○

↳ Specify 'Other': _____

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

- ○ Yes
- ○ No

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

- ○ Yes →
- ○ No

If yes:

	Yes	No
a. Did you have a chest X-ray?	○	○
b. Did you have a CT scan of your lungs?	○	○
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?

○ Yes ⟶
○ No

If yes:

a. How many nights were you in the hospital?

i. Date arrived at hospital: _____

ii. Date discharged from hospital: _____

b. Did you require any of the following treatments?	Yes	No	# Days needed
i. Oxygen by nasal canula (in your nose)	○	○	_____
ii. Oxygen by face mask	○	○	_____
iii. "Intensive care unit" or ICU monitoring	○	○	_____
iv. A breathing tube or ventilator	○	○	_____
v. "ECMO" treatment	○	○	_____

For ascertainment of medical records:

Name of doctor/clinic/hospital: _____

Address of doctor/clinic/hospital: _____

_____

Contact number: _____

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

	Yes	No
a. Home	○	○
b. Nursing facility	○	○
c. Other	○	○

↳ Specify 'Other': _____

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

○ Yes ⟶
○ No

If yes:

a. How long did it take for you to recover? _____ 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?	**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	○ Yes ○ No		
Trouble breathing	○ Yes ○ No		
Chest congestion	○ Yes ○ No		
Chest tightness	○ Yes ○ No		
Dry or hacking cough	○ Yes ○ No		
Wet or loose cough	○ Yes ○ No		
Body aches or pains	○ Yes ○ No		
Chills or shivering	○ Yes ○ No		
Sore or painful throat	○ Yes ○ No		
Congested or stuffy nose	○ Yes ○ No		
Runny or dripping nose	○ Yes ○ No		
Diarrhea	○ Yes ○ No		
Weak or tired	○ Yes ○ No		
Loss of smell	○ Yes ○ No		
Loss of taste	○ Yes ○ No		

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)

○ Mild ○ Moderate ○ Severe ○ 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)

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much

Skip to question 9

If no to Q7:

For participants who continue to have 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?	**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	○ Yes ○ No		
Trouble breathing	○ Yes ○ No		
Chest congestion	○ Yes ○ No		
Chest tightness	○ Yes ○ No		
Dry or hacking cough	○ Yes ○ No		
Wet or loose cough	○ Yes ○ No		
Body aches or pains	○ Yes ○ No		
Chills or shivering	○ Yes ○ No		
Sore or painful throat	○ Yes ○ No		
Congested or stuffy nose	○ Yes ○ No		
Runny or dripping nose	○ Yes ○ No		
Diarrhea	○ Yes ○ No		
Weak or tired	○ Yes ○ No		
Loss of smell	○ Yes ○ No		
Loss of taste	○ Yes ○ No		

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)

○ Mild ○ Moderate ○ Severe ○ 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)

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ 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?	**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	○ Yes ○ No		
Trouble breathing	○ Yes ○ No		
Chest congestion	○ Yes ○ No		
Chest tightness	○ Yes ○ No		
Dry or hacking cough	○ Yes ○ No		
Wet or loose cough	○ Yes ○ No		
Body aches or pains	○ Yes ○ No		
Chills or shivering	○ Yes ○ No		
Sore or painful throat	○ Yes ○ No		
Congested or stuffy nose	○ Yes ○ No		
Runny or dripping nose	○ Yes ○ No		
Diarrhea	○ Yes ○ No		
Weak or tired	○ Yes ○ No		
Loss of smell	○ Yes ○ No		
Loss of taste	○ Yes ○ No		
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) ○ Mild ○ Moderate ○ Severe ○ 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) ○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much			

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

- ○ Yes
- ○ No

If yes:

Medicine	Did you take it?	Was is prescribed by health care professional?	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	○ Yes ○ No	○ Yes ○ No			
Ibuprofen, Motrin, Advil, Aleve	○ Yes ○ No	○ Yes ○ No			
Cough medicine, Robitussin	○ Yes ○ No	○ Yes ○ No			
"Cold and Flu" medicine	○ Yes ○ No	○ Yes ○ No			
Antibiotic (e.g., azithromycin, augmentin, ciprofloxacin)	○ Yes ○ No	○ Yes ○ No			
Oral corticosteroids (e.g., prednisone, prednisolone, methylprednisone)	○ Yes ○ No	○ Yes ○ No			
Inhaled corticosteroids (e.g., flovent, symbicort, Advair)	○ Yes ○ No	○ Yes ○ No			
Other medicines	○ Yes ○ No	○ Yes ○ No			

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

- ○ Yes →
- ○ No
- ○ Unsure

If yes:

a. When was the first test conducted? _____

b. What was the result of the first test?

- ○ Positive
- ○ Negative
- ○ Unsure

Was there a second test?

- ○ Yes →
- ○ No

If yes:

a. When was the second test conducted? _____

b. What was the result of the second test?

- ○ Positive
- ○ Negative
- ○ Unsure

Was there a third test?

- ○ Yes →
- ○ No

If yes:

a. When was the third test conducted? _____

b. What was the result of the third test?

- ○ Positive
- ○ Negative
- ○ Unsure

Was there a fourth test?

- ○ Yes →
- ○ No

If yes:

a. When was the fourth test conducted? _____

b. What was the result of that test?

- ○ Positive
- ○ Negative
- ○ Unsure

(continued)

(continued)

If any of the tests were positive:

Did you change your behavior at home?

○ Yes →

○ No

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

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

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

or ○ Not applicable

12. Do you currently use any tobacco products?

	Yes	No
a. Cigarettes	○	○
b. Pipes	○	○
c. Cigars	○	○
d. E-cigarettes	○	○
e. Other	○	○

→ Cigarettes per day: _____

→ Specify 'Other': _____

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

- ○ Yes
- ○ No

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

- ○ Yes →
- ○ No

If yes:

a. What was the result of the flu test?

- ○ Positive
- ○ Negative

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

- ○ Yes
- ○ No