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