Study ID: ____________ Acrostic: ____________

Date completed (month/day/year): _______ / _______ / _______

1. Have you been diagnosed with covid-19 by a doctor or other health care provider?

O Yes ↓ O No ↓ O I'm not sure

a. Were you hospitalized?
O Yes ↓ O No O I'm not sure

i. How many days were you in the hospital? ______________

b. What symptoms did you have? (mark all that apply)
O fever O cough
O shortness of breath
O diarrhea O vomiting
O temporary loss of smell

c. Have you had any of the following symptoms since the beginning of 2020? (Mark all that apply)
O fever O cough
O shortness of breath
O diarrhea O vomiting
O temporary loss of smell
O I had none of these symptoms

d. Were any of the above symptoms due to a condition or disease other than covid-19?
O Yes O No O I'm not sure O I didn't have any symptoms

2. Has a close friend or family member been diagnosed with covid-19?

O Yes O No O I'm not sure