COVID-19: IMPACT OF THE PANDEMIC AND HRQOL IN CANCER PATIENTS AND SURVIVORS

I. COVID-19 EXPERIENCES

Please answer the questions below to the best of your knowledge. If the item is not applicable, please select N/A. If you do not know the answer, please select D/K.

1. To your knowledge, have you been exposed to someone with COVID-19? Yes No D/K
2. Have you been tested for COVID-19? Yes No D/K
   a. How many days ago were you tested? __ __ Days
   b. If tested, was your result positive: Yes No D/K
   c. If positive, are you currently experiencing COVID-19 symptoms? Yes No D/K
3. If you tested positive for COVID-19, were you hospitalized? Yes No N/A
   a. If you were hospitalized, how many nights were you in the hospital? __ __ Nights N/A
4. Did a family member or a member of your household test positive for COVID-19? Yes No D/K
   a. If yes, how many? __ __ N/A
5. Did a family member or a member of your household die of COVID-19? Yes No
   a. If yes, did they have COVID-19 symptoms (e.g., fever, cough)? Yes No
6. Were any friends, co-workers or neighbors diagnosed with COVID-19? Yes No
   a. If yes, how many? __ __
7. Did a friend, co-worker or neighbor die of COVID-19? Yes No
   a. If yes, how many? __ __ N/A
8. If you practiced social isolation/stay at home/quarantine, for how many days did it last (total number of days up to today if still practicing isolation)? __ __ N/A
9. Do you have any of the following risk factors or experienced symptoms associated with COVID-19:
   a. ≥ 60 years of age Yes No
   b. Comorbidities such as diabetes, hypertension, kidney disease, and/or respiratory illnesses (e.g., COPD, asthma) Yes No
   c. International travel or travel to COVID-19 hotspots Yes No
   d. Exposure to someone who tested positive to COVID-19 Yes No
   e. Visiting/working in a nursing home or hospital Yes No
   f. Fever Yes No
   g. Dry cough Yes No
   h. Shortness of breath Yes No
10. Did you lose your job or primary source of income due to COVID-19? Yes No N/A
11. Did your spouse or partner lose their job or primary source of income? Yes No N/A
12. If employed, are you currently: ___ working from home ___ commuting to work N/A
13. Due to COVID-19, my household income has: __ Decreased __ Increased __ Not changed
    a. If your income decreased, what was the reason (check as many as apply):
       __ Lost job __ Spouse/Partner lost job __ Assisting family __ Inability to work at home __ Other
    b. If your income increased, what was the reason (check as many as apply):
       __ Started a new job __ Spouse/Partner started new job __ My work became busier __ Other
14. How often are you spending time outside your home?
    __ No time __ once a week __ every 2-3 days __ normal routine
15. Are you accomplishing more or less (e.g., activities, tasks, hobbies, interests)? More Less Same
16. Due to COVID-19, did you decide not to:
    a. Attend a scheduled in-person **general medical appointment** not cancelled due to COVID-19? Yes No
    b. Attend a scheduled in-person **cancer appointment or treatment** not cancelled due to COVID-19? Yes No
    c. Seek **emergency care** in an urgent care facility or emergency room? Yes No
17. Did you participate in a Telehealth **medical appointment** (e.g., Zoom, Facetime) since COVID-19 pandemic? If yes, how many? __ __ __
    If yes, how many were for **cancer care**? __ __ __ How many were for other **medical care**? __ __ __
18. If you had a Telehealth appointment for **cancer care**, how satisfied are you with your experience?
    __ Very dissatisfied __ Somewhat dissatisfied __ Neutral __ Somewhat Satisfied __ Very Satisfied
19. If you had a Telehealth appointment for **general care**, how satisfied are you with your experience?
    __ Very dissatisfied __ Somewhat dissatisfied __ Neutral __ Somewhat Satisfied __ Very Satisfied