Personal Profile

1. Type your first name below.

2. What is your date of birth?

3. What is your email address?

4. What is your mobile phone number?

5. What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to answer

Are you currently pregnant or is there a chance you could be pregnant during the next month?

- ☐ Yes
- ☐ No

6. Does your current gender identify match your sex assigned at birth?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

7. How old are you: _____ years old

8. How much do you weigh: _____ *lbs.*

9. How tall are you? _____ *feet* _____ *inch (es)*

10. What is your ethnicity/ancestry? (check all that apply)

- ☐ Hispanic or Latino
- ☐ White – European
- ☐ Asian
- ☐ Black
- ☐ Native American
- ☐ Pacific Islander
- ☐ Don't know
- ☐ Prefer not to answer

11. Do you live alone?

☐ Yes
☐ No

Please indicate ages for people who interact in your household? (including yourself, any caregivers or roommates -- check all that apply)

☐ __ under 3 years
☐ __ 3-6 years
☐ __ 7-17 years
☐ __ 18-25 years
☐ __ 26-40 years
☐ __ 41-64 years
☐ __ 65-79 years
☐ 80 years old or older

13. What is your address? (For geocoding purposes only)

COVID-19 related questions

14. Have you been diagnosed with COVID-19

☐ Yes
☐ No

15. Were you tested for COVID-19?

☐ Yes
☐ No

Where were you tested for COVID-19?

☐ Outpatient office or lab/drive through
☐ Emergency Department
☐ Other

What is the "other" testing location indicated above?

Did you have symptoms when you were tested?

☐ Yes
☐ No

Why were you tested?

☐ Healthcare worker / first responder
☐ Susceptible family member at home
☐ Other

What "other" reason did you have for testing?

16. Please describe your symptoms:

- ☐ none
- ☐ cough, for how many days __
- ☐ sore throat, for how many days __
- ☐ fever >100.4, for how many days __
- ☐ maximum temperature recorded ____
- ☐ chills
- ☐ headache
- ☐ partial loss of smell (partial anosmia)
- ☐ complete loss of smell (anosmia)
- ☐ partial loss of taste (partial ageusia)
- ☐ complete loss of taste (ageusia)
- ☐ breathing problems
- ☐ fatigue / lethargy
- ☐ muscle pain
- ☐ runny nose
- ☐ diarrhea (>=3 loose/looser than normal stools/24 hr. period)
- ☐ nausea or vomiting
- ☐ blush lips/face
- ☐ confusion or inability to arouse
- ☐ chest pressure/ chest pain
- ☐ mild conjunctivitis or red eye
- ☐ Other, specify

How many days of coughing (if you remember)?

Please describe type of cough:

- ☐ dry
- ☐ wet
- ☐ other _____

Date of your first symptom

Date of symptom resolution (if known)

17. Were you abroad just before getting sick / being exposed to or being suspected for COVID-19 infection?

- ☐ no
- ☐ yes, country: _____ exact dates of travel: _____

18. Were you exposed to an individual known or suspected to have COVID-19?

- ☐ yes; known

- ☐ yes; suspected
- ☐ no
- ☐ not sure

General Health questions:

19. How would you rate your general health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

20. Describe your usual level of social interactions with other people when not under stay at home and/or social distancing.

- ☐ I go out a lot (4-7 times/week)
- ☐ I go out sometimes (2-3 times/week)
- ☐ I keep to myself mainly (1 or less times/week)

21. How would you rate your compliance on a scale of 1-5 about social distancing measures as recommended by CDC? (1 being not following guidelines to 5 being following all guidelines).

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5

22. Has your doctor or any medical provider ever told you that you have any of the following diseases? **(check all that apply)**

- ☐ Lung disease
  a. Asthma
  b. Chronic obstructive pulmonary disorder
  c. Idiopathic pulmonary fibrosis
  d. Bronchiectasis
  e. Alpha-1 antitrypsin deficiency
  f. Other lung disorders
- ☐ Heart disease
  a. Congenital Heart disease
  b. Coronary artery disease or history of heart attack
  c. Congestive heart failure
- ☐ Hypertension/high blood pressure
- ☐ Hyperlipidemia/ hypercholesterolemia/high cholesterol
- ☐ Anemia
- ☐ Liver disease

- ☐ Diabetes
- ☐ Obesity
- ☐ Joint diseases
  a. Rheumatoid arthritis
  b. Osteoarthritis or joint disease
- ☐ Inflammatory bowel disease
- ☐ Cancer
- ☐ Cystic Fibrosis
- ☐ Chronic Kidney Disease
- ☐ Neurological disorder (e.g., ALS, multiple sclerosis, Parkinson's, Huntington's)
- ☐ Dementia/Alzheimer's disease
- ☐ Other, please specify _____
- ☐ None of the above

23. Have you ever had an organ transplant?

- ☐ No
- ☐ yes, which organ? _____

24. Have you ever been diagnosed with an immune related condition?

- ☐ Autoimmune condition (indicate all the apply)
  thyroid, lupus, multiple sclerosis, cytopenia, colitis/inflammatory bowel disease, other: _____
- ☐ Inflammatory condition - which one: _____
- ☐ Periodic/Frequent fevers
- ☐ Immune deficiency
- ☐ Recurrent warts or viral skin infections
- ☐ Season allergies/hay fever
- ☐ Food allergies
- ☐ Cold sores
- ☐ Shingles
- ☐ Eczema
- ☐ Hives
- ☐ None of the above

25. Are you currently taking any of the following daily, several times a week or at least once a week? (Check all that apply)

- ☐ Aspirin, with or without a prescription.
- ☐ Non-steroidal anti-inflammatory agents (NSAIDS) with or without a prescription: (eg. ibuprofen (Motrin, Advil), naproxen (Naprosyn, Aleve, Anaprox, Naprelan), diclofenac (Cambia, Cataflam, Voltaren, Zipsor), indomethacin (Indocin), diflunisal, etodolac, ketoprofen, ketorolac, nambumetone, oxaprozin (Daypro), piroxicam (Feldene), salsalate (Disalate), sulidnac, tolmetin, celecoxib (Celebrex)
- ☐ Acetaminophen (Tylenol and others)

- ☐ Oral corticosteroids (eg. Prednisone)
- ☐ Inhaled corticosteroids (eg. fluticasone (Flovent), beclomethasone (QVar), etc)
- ☐ Inhaled bronchodialators (eg. albuterol)
- ☐ Other Asthma Medications
- ☐ Nerve pain medication (eg. gabapetin)
- ☐ Diabetes medication
- ☐ Anti-TNF medications (infliximab, adalimumab, certolizumab, golimumab, etanercept, others)
- ☐ IL-6 pathway inhibitors (sarilumab,tocilizumab, siltuximab, others)
- ☐ Conventional disease-modifying anti-rheumatic drugs (DMARDs) (eg. cyclosporin, cyclophosphamide, hydroxychloroquine, leflunomide, methotrexate, mycophenolate, sulfasalazine)
- ☐ JAK Inhibitors (Baricitinib, ruxolitinib, fedratinib, tofacitinib)
- ☐ Blood thinning medication (eg. warfarin (Coumadin), heparin, enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), etc)
- ☐ Platelet inhibitors (eg. clopidogrel (Plavix), prasugrel (Effient), ticagrelor (Brilinta), etc.)
- ☐ Blood pressure medication: ACE inhibitors (eg. benazepril, captopril, enalapril, fosinopril, lisinopril, etc.)
- ☐ Blood pressure medication: Angiotensin Receptor Blockers (eg. losartan, valsartan, irbesartan, candesartan, telmisartan, Olmesartan, etc)
- ☐ Blood pressure medication: beta-blockers (eg. metoprolol, atenolol, carvedilol, etc.)
- ☐ Blood pressure medication: others
- ☐ Cholesterol medication: Statins (eg. atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin, fluvastatin, pitavastatin)
- ☐ Cholesterol medication: others (ezetimibe, fenofibrate, etc)
- ☐ Thyroid medication (eg. levothryroxine, Synthroid)
- ☐ Other (prescribed/non-prescribed/vitamins or supplements)
- ☐ None of the above

26. **Did you get a flu vaccine this season (last 6 months)?**

- ☐ Yes, date (if remember) _____
- ☐ No
- ☐ Do not remember

27. Do you remember last time you got flu or flu-like illness prior to COVID pandemic?

- ☐ Yes, When? _____
- ☐ No

Did you get hospitalized due to flu?

- ☐ Yes
- ☐ No

28. How often you get flu or flu-like illness?

- ☐ Never
- ☐ Rarely
- ☐ Once a year
- ☐ Twice a year or more

29. When were you on your last course of antibiotics?

- ☐ Currently
- ☐ This month
- ☐ Last month
- ☐ In past 2 months
- ☐ In past 6 months
- ☐ In last year
- ☐ Over a year
- ☐ Never/Do not remember

Personal Lifestyle questions:

30. Do you take any recreational drugs like marijuana?

- ☐ no
- ☐ yes, how often? _____

31. Do you smoke?

- ☐ I have never smoked
- ☐ I have never smoked regularly.
- ☐ I used to smoke, but I quit.
- ☐ I smoke only rarely.
- ☐ I smoke every day. How many cigarettes on average per day: _____

32. Do you vape?

- ☐ I have never vaped
- ☐ I have never vaped regularly.
- ☐ I used to vape, but I quit.
- ☐ I vape only rarely.
- ☐ I vape every day.

33. What is your education level?

- ☐ Primary/elementary school
- ☐ Vocational school
- ☐ High school
- ☐ College/Bachelor's degree
- ☐ Master's degree or higher

34. What is your job title: _____

35. Are you exposed to any particular hazards in your job?

- ☐ Fumes
- ☐ Medical facilities
- ☐ Lead
- ☐ Asbestos
- ☐ Work that causes excessive sweat/dehydration/physical
- ☐ Other
- ☐ None of the above

36. What is the level of your usual physical activity?

- ☐ I read, watch TV, and perform chores that are not physically taxing
- ☐ I walk, bike, or are otherwise physically active for many days a week. Including among other activities: walking, fishing, hunting, and light gardening work
- ☐ I do endurance sports for many hours a week. Including jogging, skiing, weight lifting, calisthenics, swimming, ball games and physically taxing gardening work.
- ☐ I train for competitive sports for regularly, many times a week.