COVID-19 related questions

1. Have you been diagnosed with COVID-19

- ☐ Yes
- ☐ No

2. 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?

3. 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)

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

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

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

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

Contains questions 14-18 from full survey