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
   b. COVID-19 immunity?  
      - Yes  
      - No
      - Result:  
        - Positive  
        - Negative
   c. How many times have you been tested? _____________
   d. Can you provide details regarding your first COVID-19 test?
      i. Date: ________________
      ii. Reason for testing:  
        Yes  
        No
        1. I had symptoms of COVID-19  
           O  
           O
        2. Someone I know had symptoms of COVID-19  
           O  
           O
        3. A doctor told me to be tested for COVID-19  
           O  
           O
        4. I was worried about COVID-19  
           O  
           O
        5. Other: __________________________

   (continued)
(continued)

iii. Type of test:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nasopharyngeal swab</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. Blood test</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. Saliva test</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. Other: ____________________</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

iv. Result:

- Positive
- Negative
- Unsure

e. Can you provide details regarding your most recent COVID-19 test?

i. Date: ________________

ii. Reason for testing:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I had symptoms of COVID-19</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. Someone I know had symptoms of COVID-19</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. A doctor told me to be tested for COVID-19</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. I was worried about COVID-19</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. Other: ____________________</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

iii. Type of test:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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<td>O</td>
<td>O</td>
</tr>
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</tr>
<tr>
<td>3. Saliva test</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. Other: ____________________</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

iv. Result:

- Positive
- Negative
- Unsure

(continued)
COVID-19
Questionnaire

(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:

   a. I had symptoms of COVID-19  
      Yes  No
   b. Someone I know had symptoms of COVID-19  
      Yes  No
   c. A doctor told me to be tested for COVID-19  
      Yes  No
   d. I was worried about COVID-19  
      Yes  No
   e. Other: ____________________________  
      Yes  No

3. Type of test:

   a. Nasopharyngeal swab  
      Yes  No
   b. Blood test  
      Yes  No
   c. Saliva test  
      Yes  No
   d. Other: ____________________________  
      Yes  No

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:

- Did you have a chest X-ray?  
  Yes  No
- Did you have a CT scan of your lungs?  
  Yes  No
- Are you willing to have your lung images shared with the study?  
  Yes  No
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?
   i. Oxygen by nasal canula (in your nose) ❏ Yes ❏ No # Days needed ____________
   ii. Oxygen by face mask ❏ Yes ❏ No # Days needed ____________
   iii. “Intensive care unit” or ICU monitoring ❏ Yes ❏ No # Days needed ____________
   iv. A breathing tube or ventilator ❏ Yes ❏ No # Days needed ____________
   v. “ECMO” treatment ❏ Yes ❏ No # Days needed ____________

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?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Home</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b. Nursing facility</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>c. Other: ___________________________</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

7. If you know, or believe, that you had COVID-19: have you recovered to your usual state of health?

☐ Yes  ➔ If yes:

☐ No

   a. How long did it take for you to recover? _______ days

Continue to next page
**If yes to Q7:**

For participants who have recovered from symptoms related to COVID-19 illness:

<table>
<thead>
<tr>
<th></th>
<th>A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?</th>
<th>B. When the symptom was at its worst, how much did it bother you, on a scale of 1 (not at all) to 5 (very much)?</th>
<th>C. How long, in days, did the symptom last?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble breathing</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest congestion</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest tightness</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry or hacking cough</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wet or loose cough</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body aches or pains</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chills or shivering</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore or painful throat</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congested or stuffy nose</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny or dripping nose</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weak or tired</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of smell</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of taste</td>
<td>O Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)</td>
<td>O Mild</td>
<td>O Moderate</td>
<td>O Severe</td>
</tr>
<tr>
<td>Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)</td>
<td>O Not at all</td>
<td>O A little bit</td>
<td>O Somewhat</td>
</tr>
</tbody>
</table>

*Skip to question 9*
If no to Q7:

For participants who continue to have symptoms related to COVID-19 illness:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?</th>
<th>B. When the symptom was at its worst, how much did it bother you, on a scale of 1 (not at all) to 5 (very much)?</th>
<th>C. How long, in days, has this symptom bothered you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble breathing</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
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<td>Chest tightness</td>
<td>○ Yes ○ No</td>
<td></td>
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<tr>
<td>Dry or hacking cough</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
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<tr>
<td>Wet or loose cough</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body aches or pains</td>
<td>○ Yes ○ No</td>
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<tr>
<td>Chills or shivering</td>
<td>○ Yes ○ No</td>
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<tr>
<td>Sore or painful throat</td>
<td>○ Yes ○ No</td>
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<td>Congested or stuffy nose</td>
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<td>Diarrhea</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
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<tr>
<td>Weak or tired</td>
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<td></td>
</tr>
<tr>
<td>Loss of smell</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of taste</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

○ Mild ○ Moderate ○ Severe ○ Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much
8. If you have not had diagnosed or suspected COVID-19 illness, have you had any of the following symptoms since our last call?

For participants who do not report diagnosed or suspected COVID-19:

<table>
<thead>
<tr>
<th>A. Have you experienced worsening of this symptom compared to your usual state of health?</th>
<th>B. When the symptom was at its worst, how much did it bother you, on a scale of 1 (not at all) to 5 (very much)?</th>
<th>C. How long, in days, did the symptom last?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>○ Yes ○ No</td>
<td></td>
</tr>
<tr>
<td>Trouble breathing</td>
<td>○ Yes ○ No</td>
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<td>Diarrhea</td>
<td>○ Yes ○ No</td>
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<td>Weak or tired</td>
<td>○ Yes ○ No</td>
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<td>○ Yes ○ No</td>
<td></td>
</tr>
<tr>
<td>Loss of taste</td>
<td>○ Yes ○ No</td>
<td></td>
</tr>
</tbody>
</table>

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

○ Mild ○ Moderate ○ Severe ○ Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much
9. If you had any of the symptoms we talked about, did you take any medicines?
   ○ Yes
   ○ No

*If yes:*

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Did you take it?</th>
<th>Was is prescribed by health care professional?</th>
<th>What was the date when you started to take it?</th>
<th>What was the total number of days that you took it?</th>
<th>What was the specific name of the medication?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen, Tylenol</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ibuprofen, Motrin, Advil, Aleve</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough medicine, Robitussin</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Cold and Flu” medicine</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic (e.g., azithromycin, augmentin, ciprofloxacin)</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral corticosteroids (e.g., prednisone, prednisolone, methylprednisone)</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhaled corticosteroids (e.g., flonentr, symbicort, Advair)</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medicines</td>
<td>○ Yes ○ No</td>
<td>○ Yes ○ No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COVID-19
Questionnaire

10. Has anyone in your household (or, the place you are residing) been tested for COVID-19?
   ○ Yes
   ○ No
   ○ Unsure

   If yes:
   a. When was/were the tests conducted? __________
   b. What was the result of that (those) test(s)?
      ○ Positive
      ○ Negative
      ○ Unsure

   Repeat questions a and b for up to four COVID-19 tests.

   If any of the tests were positive:
   Did you change your behavior at home?
   ○ Yes
   ○ No

<table>
<thead>
<tr>
<th>Did you wear a mask at home?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the infected person(s) wear a mask at home?</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did the infected person(s) stay away from you?</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

11. What actions have you taken to reduce your risk of exposure to COVID-19?

   a. Washing hands and/or using sanitizer frequently ○ ○
   b. Staying at least 6 feet away from others ○ ○
   c. Avoiding large gatherings ○ ○
   d. Not going out to restaurants or bars ○ ○
   e. Cancelled planned travel ○ ○
   f. Wearing a face mask ○ ○
   g. Not shaking hands or touching people ○ ○
   h. Staying home when I am sick ○ ○
   i. Not going to work ○ ○
   j. Wiping down surfaces with disinfectant ○ ○
   k. Following government guidelines or rules to stay at home and limiting contacts with other people ○ ○
   l. Placed under full quarantine by local authorities ○ ○

   or ○ Not applicable
12. Do you currently use any tobacco products?

   Yes   No
   a. Cigarettes ○ ○
      Cigarettes per day: _______
   b. Pipes ○ ○
   c. Cigars ○ ○
   d. E-cigarettes ○ ○
   e. Other: ________________

13. Did you receive vaccination for influenza ("the flu shot") between September 2019 and March 2020?
   ○ Yes
   ○ No

14. Have you had a test for influenza since January 2020?
   ○ Yes ➔ If yes:
   ○ No

   a. What was the result of the flu test?
      ○ Positive
      ○ Negative
   b. Was this test performed at the same time as a COVID-19 test?
      ○ Yes
      ○ No