



COVID-19 Questionnaire

Participant ID #:

Acrostic:

Interviewer ID:

Date: / /
Month Day Year

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



**COVID-19
Questionnaire**

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

2. Someone I know had symptoms of COVID-19

3. A doctor told me to be tested for COVID-19

4. I was worried about COVID-19

5. Other: _____

(continued)



(continued)

iii. Type of test:	Yes	No
1. Nasopharyngeal swab	<input type="radio"/>	<input type="radio"/>
2. Blood test	<input type="radio"/>	<input type="radio"/>
3. Saliva test	<input type="radio"/>	<input type="radio"/>
4. Other: _____	<input type="radio"/>	<input type="radio"/>

- iv. Result:
- Positive
 - Negative
 - Unsure

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

i. Date: _____

ii. Reason for testing:	Yes	No
1. I had symptoms of COVID-19	<input type="radio"/>	<input type="radio"/>
2. Someone I know had symptoms of COVID-19	<input type="radio"/>	<input type="radio"/>
3. A doctor told me to be tested for COVID-19	<input type="radio"/>	<input type="radio"/>
4. I was worried about COVID-19	<input type="radio"/>	<input type="radio"/>
5. Other: _____	<input type="radio"/>	<input type="radio"/>

iii. Type of test:	Yes	No
1. Nasopharyngeal swab	<input type="radio"/>	<input type="radio"/>
2. Blood test	<input type="radio"/>	<input type="radio"/>
3. Saliva test	<input type="radio"/>	<input type="radio"/>
4. Other: _____	<input type="radio"/>	<input type="radio"/>

- iv. Result:
- Positive
 - Negative
 - Unsure

(continued)



(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:	Yes	No
a. I had symptoms of COVID-19	<input type="radio"/>	<input type="radio"/>
b. Someone I know had symptoms of COVID-19	<input type="radio"/>	<input type="radio"/>
c. A doctor told me to be tested for COVID-19	<input type="radio"/>	<input type="radio"/>
d. I was worried about COVID-19	<input type="radio"/>	<input type="radio"/>
e. Other: _____	<input type="radio"/>	<input type="radio"/>

3. Type of test:	Yes	No
a. Nasopharyngeal swab	<input type="radio"/>	<input type="radio"/>
b. Blood test	<input type="radio"/>	<input type="radio"/>
c. Saliva test	<input type="radio"/>	<input type="radio"/>
d. Other: _____	<input type="radio"/>	<input type="radio"/>

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:

	Yes	No
a. Did you have a chest X-ray?	<input type="radio"/>	<input type="radio"/>
b. Did you have a CT scan of your lungs?	<input type="radio"/>	<input type="radio"/>
c. Are you willing to have your lung images shared with the study?	<input type="radio"/>	<input type="radio"/>



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

iii. "Intensive care unit" or ICU monitoring

iv. A breathing tube or ventilator

v. "ECMO" treatment

For ascertainment of medical records:

Name of doctor/clinic/hospital: _____

Address of doctor/clinic/hospital: _____

Contact number: _____



**COVID-19
Questionnaire**

6. If you were hospitalized for suspected or diagnosed COVID-19, how were you discharged?

- | | Yes | No |
|---------------------|-----------------------|-----------------------|
| a. Home | <input type="radio"/> | <input type="radio"/> |
| b. Nursing facility | <input type="radio"/> | <input type="radio"/> |
| c. Other: _____ | <input type="radio"/> | <input type="radio"/> |

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

- Yes →
- No

If yes:

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

Continue to next page



**COVID-19
Questionnaire**

If yes to Q7:

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

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?	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)?	C. How long, in days, did the symptom last?
Fever	<input type="radio"/> Yes <input type="radio"/> No		
Trouble breathing	<input type="radio"/> Yes <input type="radio"/> No		
Chest congestion	<input type="radio"/> Yes <input type="radio"/> No		
Chest tightness	<input type="radio"/> Yes <input type="radio"/> No		
Dry or hacking cough	<input type="radio"/> Yes <input type="radio"/> No		
Wet or loose cough	<input type="radio"/> Yes <input type="radio"/> No		
Body aches or pains	<input type="radio"/> Yes <input type="radio"/> No		
Chills or shivering	<input type="radio"/> Yes <input type="radio"/> No		
Sore or painful throat	<input type="radio"/> Yes <input type="radio"/> No		
Congested or stuffy nose	<input type="radio"/> Yes <input type="radio"/> No		
Runny or dripping nose	<input type="radio"/> Yes <input type="radio"/> No		
Diarrhea	<input type="radio"/> Yes <input type="radio"/> No		
Weak or tired	<input type="radio"/> Yes <input type="radio"/> No		
Loss of smell	<input type="radio"/> Yes <input type="radio"/> No		
Loss of taste	<input type="radio"/> Yes <input type="radio"/> No		
<p>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)</p> <p><input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Very Severe</p>			
<p>Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)</p> <p><input type="radio"/> Not at all <input type="radio"/> A little bit <input type="radio"/> Somewhat <input type="radio"/> Quite a bit <input type="radio"/> Very much</p>			

Skip to question 9



**COVID-19
Questionnaire**

If no to Q7:

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

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?	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)?	C. How long, in days, has this symptom bothered you?
Fever	<input type="radio"/> Yes <input type="radio"/> No		
Trouble breathing	<input type="radio"/> Yes <input type="radio"/> No		
Chest congestion	<input type="radio"/> Yes <input type="radio"/> No		
Chest tightness	<input type="radio"/> Yes <input type="radio"/> No		
Dry or hacking cough	<input type="radio"/> Yes <input type="radio"/> No		
Wet or loose cough	<input type="radio"/> Yes <input type="radio"/> No		
Body aches or pains	<input type="radio"/> Yes <input type="radio"/> No		
Chills or shivering	<input type="radio"/> Yes <input type="radio"/> No		
Sore or painful throat	<input type="radio"/> Yes <input type="radio"/> No		
Congested or stuffy nose	<input type="radio"/> Yes <input type="radio"/> No		
Runny or dripping nose	<input type="radio"/> Yes <input type="radio"/> No		
Diarrhea	<input type="radio"/> Yes <input type="radio"/> No		
Weak or tired	<input type="radio"/> Yes <input type="radio"/> No		
Loss of smell	<input type="radio"/> Yes <input type="radio"/> No		
Loss of taste	<input type="radio"/> Yes <input type="radio"/> No		
<p>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)</p> <p><input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Very Severe</p>			
<p>Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)</p> <p><input type="radio"/> Not at all <input type="radio"/> A little bit <input type="radio"/> Somewhat <input type="radio"/> Quite a bit <input type="radio"/> Very much</p>			



**COVID-19
Questionnaire**

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:

	A. Have you experienced worsening of this symptom compared to your usual state of health?	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)?	C. How long, in days, did the symptom last?
Fever	<input type="radio"/> Yes <input type="radio"/> No		
Trouble breathing	<input type="radio"/> Yes <input type="radio"/> No		
Chest congestion	<input type="radio"/> Yes <input type="radio"/> No		
Chest tightness	<input type="radio"/> Yes <input type="radio"/> No		
Dry or hacking cough	<input type="radio"/> Yes <input type="radio"/> No		
Wet or loose cough	<input type="radio"/> Yes <input type="radio"/> No		
Body aches or pains	<input type="radio"/> Yes <input type="radio"/> No		
Chills or shivering	<input type="radio"/> Yes <input type="radio"/> No		
Sore or painful throat	<input type="radio"/> Yes <input type="radio"/> No		
Congested or stuffy nose	<input type="radio"/> Yes <input type="radio"/> No		
Runny or dripping nose	<input type="radio"/> Yes <input type="radio"/> No		
Diarrhea	<input type="radio"/> Yes <input type="radio"/> No		
Weak or tired	<input type="radio"/> Yes <input type="radio"/> No		
Loss of smell	<input type="radio"/> Yes <input type="radio"/> No		
Loss of taste	<input type="radio"/> Yes <input type="radio"/> No		

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



**COVID-19
Questionnaire**

9. If you had any of the symptoms we talked about, did you take any medicines?

- Yes
- No

If yes:

Medicine	Did you take it?	Was is prescribed by health care professional?	What was the date when you started to take it?	What was the total number of days that you took it?	What was the specific name of the medication?
Acetaminophen, Tylenol	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Ibuprofen, Motrin, Advil, Aleve	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Cough medicine, Robitussin	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
“Cold and Flu” medicine	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Antibiotic (e.g., azithromycin, augmentin, ciprofloxacin)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Oral corticosteroids (e.g., prednisone, prednisolone, methylprednisone)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Inhaled corticosteroids (e.g., flovent, symbicort, Advair)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			
Other medicines	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No			



**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

	Yes	No
Did you wear a mask at home?	<input type="radio"/>	<input type="radio"/>
Did the infected person(s) wear a mask at home?	<input type="radio"/>	<input type="radio"/>
Did the infected person(s) stay away from you?	<input type="radio"/>	<input type="radio"/>

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

- | | Yes | No | |
|---|-----------------------|-----------------------|---|
| a. Washing hands and/or using sanitizer frequently | <input type="radio"/> | <input type="radio"/> | |
| b. Staying at least 6 feet away from others | <input type="radio"/> | <input type="radio"/> | |
| c. Avoiding large gatherings | <input type="radio"/> | <input type="radio"/> | |
| d. Not going out to restaurants or bars | <input type="radio"/> | <input type="radio"/> | |
| e. Cancelled planned travel | <input type="radio"/> | <input type="radio"/> | |
| f. Wearing a face mask | <input type="radio"/> | <input type="radio"/> | |
| g. Not shaking hands or touching people | <input type="radio"/> | <input type="radio"/> | |
| h. Staying home when I am sick | <input type="radio"/> | <input type="radio"/> | |
| i. Not going to work | <input type="radio"/> | <input type="radio"/> | or <input type="radio"/> Not applicable |
| j. Wiping down surfaces with disinfectant | <input type="radio"/> | <input type="radio"/> | |
| k. Following government guidelines or rules to stay at home and limiting contacts with other people | <input type="radio"/> | <input type="radio"/> | |
| l. Placed under full quarantine by local authorities | <input type="radio"/> | <input type="radio"/> | |



COVID-19 Questionnaire

12. Do you currently use any tobacco products?

- | | Yes | No |
|-----------------|--|-----------------------|
| a. Cigarettes | <input type="radio"/> | <input type="radio"/> |
| | ↳ <input type="text" value="Cigarettes per day: _____"/> | |
| b. Pipes | <input type="radio"/> | <input type="radio"/> |
| c. Cigars | <input type="radio"/> | <input type="radio"/> |
| d. E-cigarettes | <input type="radio"/> | <input type="radio"/> |
| 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 →
- No

If yes:

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