COVID-19 Experiences (COVEX)

Suggested citation
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These questions are about your experiences during the coronavirus pandemic, also known as the COVID-19 outbreak.

Section 1: COVID-19 Symptoms & Diagnoses

1. Since the start of the outbreak, did you have symptoms of COVID-19? That is, have you had a fever, shortness of breath, sore throat, body aches, fatigue, runny nose or congestion, diarrhea, chills, muscle pain, headache, or a loss of taste or smell?
   - [ ] No
   - [ ] Yes
   - [ ] Not Sure

2. Which of the following symptoms have you experienced since the COVID-19 outbreak began in your area (that is, since [date])? [check all that apply]
   - [ ] Fever (above 100 degrees Fahrenheit or above 37.8 degrees Celsius)
   - [ ] Cough
   - [ ] Runny nose
   - [ ] Shortness of breath
   - [ ] Repeated shaking with chills
   - [ ] Chills (without shaking)
   - [ ] Sore throat
   - [ ] Headache
   - [ ] Muscle or body aches
   - [ ] Tingling or burning sensation
   - [ ] Fatigue
   - [ ] Excessive sleepiness
   - [ ] Diarrhea
   - [ ] Nausea or vomiting
   - [ ] Loss of sense of smell
   - [ ] Loss of sense of taste
   - [ ] Itchy/red eyes
   - [ ] Discoloration of toes or fingers (look “dusky”)
   - [ ] Sores/rashes on feet or hands
   - [ ] Stroke
   - [ ] None of the above → GO TO 3

[COVEX (Version 1.0)]
2a. How would you rate the severity of your illness?

☐ Mild illness (dry cough, headache, nausea/diarrhea, aches and pains, low-grade fever – no need to see a doctor or hospitalization)

☐ Moderate illness (coughing, high fever (above 100.0 degrees Fahrenheit or above 37.8 degrees Celsius), chills, feeling that you can’t get out of bed, shortness of breath)

☐ Severe illness (breathlessness, complications leading to pneumonia)

☐ Critical illness (respiratory failure, septic shock, and/or organ dysfunction or failure)

☐ Don’t Know

2b. Which of the following occurred as a result of your symptoms? [check all that apply]

☐ I was kept overnight in a hospital \( \Rightarrow \) GO TO 2C

☐ I saw a healthcare provider in person, such as in a clinic, doctor’s office, urgent care, or Emergency Room (ER)/Emergency Department (ED)

☐ I spoke to a healthcare provider over the phone, by email, or online

☐ I self-isolated or quarantined at home

☐ None of the above

*If kept overnight in a hospital; ask:*

2c. How many nights were you kept in the hospital __________ [days]

3. Has a healthcare provider ever told you that you have, or likely [have/have had] COVID-19 (Coronavirus)?

☐ No

☐ Yes

4. Have you been tested for COVID-19?

☐ No

☐ Yes, tested positive

☐ Yes, but never tested positive

☐ Yes, but haven’t got the results yet

*If yes, ask:*

4a. What type of test was this?

☐ Nasal swab

☐ Blood test for active infection

☐ Blood test for antibodies

☐ Saliva test

☐ Other: ____________________