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:

- Symptoms of COVID-19
  ○ Yes
  ○ No
- A positive test for COVID-19
  ○ Yes
  ○ No
- 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:

- COVID-19 infection?
  ○ Yes
  ○ No
  Result:  ○ Positive  ○ Negative  ○ Pending

- COVID-19 immunity?
  ○ Yes
  ○ No
  Result:  ○ Positive  ○ Negative  ○ Pending

- How many times have you been tested? ____________

- Can you provide details regarding your first COVID-19 test?
  i. Date: ________________
  ii. Reason for testing:

    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  ○  ○

    Specify ‘Other’: ________________________ (continued)
(continued)

iii. Type of test:  

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<tr>
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<th>Yes</th>
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<tr>
<td>1. Nasopharyngeal swab</td>
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<td>2. Blood test</td>
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Specify ‘Other’: ______________________

iv. Result:  

- Positive  
- Negative  
- Unsure/Pending

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

i. Date: ________________

ii. Reason for testing:  

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Specify ‘Other’: ______________________

iv. Result:  

- Positive  
- Negative  
- Unsure/Pending

(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

   ▶ Specify ‘Other’: ____________________

3. Type of test:

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

   ▶ Specify ‘Other’: ____________________

4. Have you had any x-ray or computed tomography (“cat”) scans for suspected or diagnosed COVID-19?

   ☐ Yes  ☐ No

If yes:

a. Did you have a chest X-ray?  ☐ Yes  ☐ No

b. Did you have a CT scan of your lungs?  ☐ Yes  ☐ No

c. 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  ___________
   iii. “Intensive care unit” or ICU monitoring
      Yes  No  ___________
   iv. A breathing tube or ventilator
      Yes  No  ___________
   v. “ECMO” treatment
      Yes  No  ___________

**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?

   a. Home
      Yes  No
   b. Nursing facility
      Yes  No
   c. Other
      Yes  No

Specify ‘Other’: ____________________________

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