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

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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:

<table>
<thead>
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<tr>
<td>a. Did you have a chest X-ray?</td>
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<tr>
<td>b. Did you have a CT scan of your lungs?</td>
<td>○</td>
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<tr>
<td>c. Are you willing to have your lung images shared with the study?</td>
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</table>
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?
   - Oxygen by nasal canula (in your nose) [ ] Yes [ ] No [ ] # Days needed
   - Oxygen by face mask [ ] Yes [ ] No [ ]
   - “Intensive care unit” or ICU monitoring [ ] Yes [ ] No [ ]
   - A breathing tube or ventilator [ ] Yes [ ] No [ ]
   - “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?

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>a. Home</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Nursing facility</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Other:</td>
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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

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