COVID-19 related questions

1. Have you been diagnosed with COVID-19
   □ Yes
   □ No

2. Were you tested for COVID-19?
   □ Yes
   □ No

   Where were you tested for COVID-19?
   □ Outpatient office or lab/drive through
   □ Emergency Department
   □ Other

   What is the “other” testing location indicated above?

   Did you have symptoms when you were tested?
   □ Yes
   □ No

   Why were you tested?
   □ Healthcare worker / first responder
   □ Susceptible family member at home
   □ Other

   What “other” reason did you have for testing?
3. Please describe your symptoms:
   - none
   - cough, for how many days __
   - sore throat, for how many days __
   - fever >100.4, for how many days __
   - maximum temperature recorded ____
   - chills
   - headache
   - partial loss of smell (partial anosmia)
   - complete loss of smell (anosmia)
   - partial loss of taste (partial ageusia)
   - complete loss of taste (ageusia)
   - breathing problems
   - fatigue / lethargy
   - muscle pain
   - runny nose
   - diarrhea (>=3 loose/looser than normal stools/24 hr. period)
   - nausea or vomiting
   - blush lips/face
   - confusion or inability to arouse
   - chest pressure/ chest pain
   - mild conjunctivitis or red eye
   - Other, specify

   **How many days of coughing (if you remember)?**

   **Please describe type of cough:**
   - dry
   - wet
   - other __________

   **Date of your first symptom**

   **Date of symptom resolution (if known)**

4. Were you abroad just before getting sick / being exposed to or being suspected for COVID-19 infection?
   - no
   - yes, country: ______________________ exact dates of travel: __________________

5. Were you exposed to an individual known or suspected to have COVID-19?
   - yes; known
   - yes; suspected
   - no
   - not sure

Contains questions 14-18 from full survey