COVID-CARE Survey Instrument

Start of Block: Eligibility

Q1.3 What is the zip code of where you currently live? Or live outside of U.S.?

* Zip code (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Live outside of the U.S. (2)

Skip To: End of Block If What is the zip code of where you currently live? Or live outside of U.S.? = Live outside of the U.S.

End of Block: Eligibility

Start of Block: COVID Testing

Q2.1 In the **past 30 days**, have you been **tested for the coronavirus**, and if so, what was **the result of your most recent test**?

* No, I have not been tested (1)
* Yes, and I tested positive (2)
* Yes, and I tested negative (3)
* Yes, and my results were inconclusive (4)
* Yes, and my results are still pending (5)

Skip To: End of Block If In the past 30 days, have you been tested for the coronavirus, and if so, what was the result of... = No, I have not been tested

Q150 What kind of COVID-19 test did you have?

* Home-based test (please provide name) (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lab-administered diagnostic PCR test (2)
* Lab-administered diagnostic antigen test (3)
* Lab-administered antibody test (4)

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Q2.2 Which of the following best describes **why you were tested** for the Coronavirus?

Please select all that apply.

* I had coronavirus symptoms (fever, cough, chills, nausea, etc…) (1)
* I came into contact with someone who has the coronavirus (2)
* I want to make sure I don’t spread the coronavirus to others (3)
* I am required by my employer or school (4)
* Other (5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

End of Block: COVID Testing

Start of Block: Flu test

Q3.1 In the **past 30 days**, have you been **tested for the flu**, and if so, what was **the result of your most recent test**?

* No, I have not been tested (1)
* Yes, and I tested positive (2)
* Yes, and I tested negative (3)
* Yes, and my results were inconclusive (4)
* Yes, and my results are still pending (5)

End of Block: Flu test

Start of Block: Symptom Block + Medication

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Q4.1 In the last **14 days,**did you experience any of the following **symptoms**?

 Please select all that apply.

* None (1)
* Fever or feeling feverish (2)
* Muscle aches (not due to exercise) (3)
* Pinkeye or Conjunctivitis (4)
* Fatigue (more than normal) (5)
* Chills (6)

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Q4.2 In the last 14 days, did you experience any of the following **respiratory symptoms**?

Please select all that apply

* None (1)
* Runny nose (2)
* Cough (3)
* Difficulty breathing (4)
* Wheezing (5)
* Shortness of breath (6)
* Chest pain (7)
* Bluish lips or face (8)
* Sore throat (21)

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Q4.3 Are these symptoms consistent with any chronic respiratory conditions you have, such as asthma, COPD, CHF, seasonal allergies, or other similar chronic conditions?

* No (1)
* Yes (2)
* Not sure (3)

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Q4.4 In the last 14 days, did you experience any of the following **gastrointestinal symptoms**?

Please select all that apply.

* None (1)
* Diarrhea (2)
* Stomach or abdominal pain (3)
* Change in or loss of appetite (4)
* Nausea or vomiting (5)

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Q4.5 Are these **symptoms** consistent with any **chronic gastrointestinal conditions you have**, such as Celiac, Crohn's, Diverticulitis, GERD, Irritable Bowel Syndrome, food allergies, or other similar chronic conditions?

* No (1)
* Yes (2)
* Not sure (3)

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Q4.6 In the last 14 days, did you experience any of the following **neurological symptoms**?

Please select all that apply.

* None (1)
* Headaches (2)
* Loss of balance (3)
* Slurred speech (4)
* New confusion (5)
* Unusual shivering or shaking (6)
* Loss of smell (7)
* Loss of taste (8)
* Any tingling/numbness/swelling in hands or feet (9)
* Seizures (10)

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Q4.7 Are these **symptoms** consistent with**any chronic neurological conditions you have**, such as migraines, stroke, or other similar chronic conditions?

* No (1)
* Yes (2)
* Not sure (3)

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Q4.8 In the last 14 days, did you experience any of the following **inflammatory symptoms**?

* None (1)
* Joint or any other unexplained pain (2)
* Red or purple rash or lesions on your toes (3)
* Unexplained rashes anywhere else (4)
* Excessive sweating (5)

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Q4.9 Are these **symptoms** consistent with any **chronic immune system conditions you have**, such as Graves' disease, Lupus, Lyme disease, Rheumatoid arthritis or other similar chronic conditions?

* No (1)
* Yes (2)
* Not sure (3)

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Q4.10 Which of the **following symptoms** occurred on the **first day you felt ill**?

Please select all that apply.

* Any tingling/numbness/swelling in hands or feet (1)
* Bluish lips or face (2)
* Change in or loss of appetite (3)
* Chest pain (4)
* Chills (5)
* Cough (6)
* Diarrhea (7)
* Difficulty breathing (8)
* Excessive sweating (9)
* Fatigue (more than normal) (10)
* Fever or feverish feeling (11)
* Headaches (12)
* Joint or any other unexplained pain (13)
* Loss of balance (14)
* Loss of taste (15)
* Loss of smell (16)
* Muscle aches (not due to exercise) (17)
* New confusion (18)
* Pinkeye or Conjunctivitis (19)
* Red or purple rash or lesions on your toes (20)
* Runny nose (21)
* Seizures (22)
* Shortness of breath (23)
* Slurred speech (24)
* Sore throat (25)
* Stomach or abdominal pain (26)
* Unexplained rashes anywhere else (27)
* Unusual shivering or shaking (28)
* Nausea or vomiting (29)
* Wheezing (30)

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Q4.11 Are you taking any **ACE Inhibitor medications** (such as Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, etc.)?

* No (1)
* Yes (2)

Q4.12 What is your blood type?

* O (1)
* A (2)
* B (3)
* AB (4)
* Don't know (5)

Q4.13 Do you have any of the underlying conditions or risk factors?
Please select all that apply.

* None (1)
* Diabetes (2)
* Hypertension (3)
* Obesity (4)
* Cardiovascular disease (5)
* Renal disease (6)
* Liver disease (7)
* Immunosuppressive disease (8)
* Current smoker (9)
* Current substance use (10)
* Pregnancy (12)
* Mental Health conditions (13)

End of Block: Symptom Block + Medication

Start of Block: Exposure

Q5.1 Have you **recovered** from a **previously diagnosed** COVID-19 illness in the last 90 days?

* No (1)
* Yes (2)

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Q5.2 In the last 14 days, did you live with, or have you been exposed to, **someone diagnosed with COVID-19 or the flu**?

Please select all that apply.

* No (1)
* Yes, with COVID-19 (2)
* Yes, with flu (3)

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Q5.3 In the last 14 days, did youregularly wear a mask indoors outside of your home?

This includes work/office, social gatherings, house of worship, medical facility, school, restaurants/bars, sports/recreation or any public transportation such as airlines, or ride sharing situations.

* No, not at all (1)
* Sometimes (2)
* Yes, always (3)

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Q5.4 In the last 14 days, did you **maintain social distancing** from other people who are **not from your household** in both indoor and outdoor spaces?

This means a safe distance (at least 6 feet) from others.

* No, not at all (1)
* Sometimes (2)
* Yes, always (3)

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Q5.5 In the last 14 days, did you **eat or drink** anything that may have given you **food poisoning**?

* No (1)
* Yes (2)

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Q5.6 Did you receive a **flu shot/vaccine** this season?

* No (1)
* Yes (2)

Q151 Did you receive a vaccine for COVID-19?

* No (1)
* Yes, both doses of a two-dose vaccine (2)
* Yes, only the 1st dose of a two-dose vaccine (3)
* Yes, one dose of a one-dose vaccine (4)

Q152 When was the last time you received the COVID-19 vaccine?

* Month (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Year (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Q5.8 Are you a **health care or an allied healthcare professional** (e.g. medical, nursing, long-term-care facility, dentistry, pharmacy, EMT/paramedic, other)?

* No (1)
* Yes (2)

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Q5.9 Are you an **essential worker (other than a healthcare professional)**required to work **in close contact with others** (e.g., retail salesperson, cashier, bus/taxi driver, firefighter, police officer, security guard, custodial staff, restaurant staff, housekeeper, childcare worker, construction worker, other)?

* No (1)
* Yes (2)

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Q5.10 In the last 14 days, did you travel to any state where COVID-19 is more prevalent than where you live?

* No (1)
* Yes (2)

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Q5.11 In the last 14 days, did you travel to any countries outside of the United States where COVID-19 is more prevalent than in the USA?

* No (1)
* Yes (2)

End of Block: Exposure

Start of Block: Demographics 2

Q153 Thank you for your answers so far. We are done with symptoms. We are now going to ask relevant background information.

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Q8.1 How would you describe **your current household/living arrangements**?

* House or single-family home (1)
* High-rise apartment building (2)
* Garden-style apartment (3)
* Nursing home or assisted living facility (4)
* Mobile home (5)
* Group home (6)

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Q8.2 How many people, **other than you**, live in the same household with you?

Please enter the number below.

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Q8.4 What is your **age** (in years)?

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Q8.5 What is your **race**?

Please select all that apply.

* White (1)
* Black or African American (2)
* Asian (3)
* American Indian or Alaska Native (4)
* Native Hawaiian or Other Pacific Islander (5)
* Other, please specify: (6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q8.6 What is your **ethnicity**?

* Hispanic Latino (1)
* Non-Hispanic Latino (2)
* Unknown (3)

Q8.7
What is your **gender**?

* Male (1)
* Female (2)
* Other (3)

End of Block: Demographics 2

Start of Block: Closure

Q9.1 Thank you for taking the time to complete this survey!

End of Block: Closure