**Appendix 1B: Full Symptom Survey Instrument**

**Symptom Screening Survey**
 Q64 You will need to complete this survey in one sitting. If you exit the survey before clicking "submit" your answers will be cleared and you will need to start over.

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covid\_tested30
In the past 30 days (outside of this research study) 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
* Yes, and I tested positive
* Yes, and I tested negative
* Yes, and my results were inconclusive
* Yes, and my results are still pending
* Prefer not to answer

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covid\_tst\_date What was the date that you were tested?
[Date Picker]

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COVID\_Result What kind of COVID-19 test did you have?

* Home-based test (please provide name)
* Lab-administered diagnostic PCR test
* Lab-administered diagnostic antigen test
* Lab-administered antibody test
* Lab-administered test, unsure of type
* Prefer not to answer

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Test\_Specify Please provide the name of the home-based test:

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COVID\_Why 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…)
* I came into contact with someone who has the coronavirus
* I want to make sure I don’t spread the coronavirus to others
* I am required by my employer or school
* Other
* ⊗Prefer not to answer

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WhyTested\_specify Other, please specify:

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covid\_tst\_symptoms Which of the following symptoms did you experience prior to getting tested? (Select all that apply)

* Any tingling/numbness/swelling in hands or feet
* Bluish lips or face
* Change in or loss of appetite
* Chest pain
* Chills
* Cough
* Diarrhea
* Difficulty breathing
* Excessive sweating
* Fatigue (more than normal)
* Fever or feverish feeling
* Headaches
* Joint or any other unexplained pain
* Loss of balance
* Loss of taste
* Loss of smell
* Muscle aches (not due to exercise)
* New confusion
* Pinkeye or Conjunctivitis
* Red or purple rash or lesions on your toes
* Runny nose
* Seizures
* Shortness of breath
* Slurred speech
* Sore throat
* Stomach or abdominal pain
* Unexplained rashes anywhere else
* Unusual shivering or shaking
* Nausea or vomiting
* Wheezing
* Other
* ⊗None of the above
* ⊗Prefer not to answer

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testsypmtoms\_specify Other, please specify:

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End of Block: COVID Testing

Start of Block: Flu test

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Flu\_Result 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
* Yes, and I tested positive
* Yes, and I tested negative
* Yes, and my results were inconclusive
* Yes, and my results are still pending
* Prefer not to answer

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flu\_tst\_date What was the date that you were tested?
[Date Picker]

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flu\_why Which of the following best describes why you were tested for the Flu?

Please select all that apply.

* I had Flu symptoms (fever, cough, chills, nausea, etc…)
* I am required by my employer or school
* Other
* ⊗Prefer not to answer

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flu\_why\_specify Other, please specify:

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flu\_tst\_symptoms Which of the following symptoms did you experience prior to getting tested? (Select all that apply)

* Any tingling/numbness/swelling in hands or feet
* Bluish lips or face
* Change in or loss of appetite
* Chest pain
* Chills
* Cough
* Diarrhea
* Difficulty breathing
* Excessive sweating
* Fatigue (more than normal)
* Fever or feverish feeling
* Headaches
* Joint or any other unexplained pain
* Loss of balance
* Loss of taste
* Loss of smell
* Muscle aches (not due to exercise)
* New confusion
* Pinkeye or Conjunctivitis
* Red or purple rash or lesions on your toes
* Runny nose
* Seizures
* Shortness of breath
* Slurred speech
* Sore throat
* Stomach or abdominal pain
* Unexplained rashes anywhere else
* Unusual shivering or shaking
* Nausea or vomiting
* Wheezing
* Other
* ⊗None of the above
* ⊗Prefer not to answer

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flu\_tst\_specify Other, please specify:

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End of Block: Flu test

Start of Block: Symptom Block + Medication

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Symptoms In the last 14 days, did you experience any of the following symptoms?

 Please select all that apply.

* ⊗None
* Fever or feeling feverish
* Muscle aches (not due to exercise)
* Pinkeye or Conjunctivitis
* Fatigue (more than normal)
* Chills
* ⊗Prefer not to answer

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Symptoms\_Resp In the last 14 days, did you experience any of the following respiratory symptoms?

Please select all that apply

* ⊗None
* Runny nose
* Cough
* Difficulty breathing
* Wheezing
* Shortness of breath
* Chest pain
* Bluish lips or face
* Sore throat
* ⊗Prefer not to answer

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Symptom\_Resp\_other Are these symptoms consistent with any chronic respiratory conditions you have, such as asthma, COPD, CHF, seasonal allergies, or other similar chronic conditions?

* No
* Yes
* Not sure
* Prefer not to answer

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Symptom\_GI In the last 14 days, did you experience any of the following gastrointestinal symptoms?

 Please select all that apply.

* ⊗None
* Diarrhea
* Stomach or abdominal pain
* Change in or loss of appetite
* Nausea or vomiting
* ⊗Prefer not to answer

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Symtpom\_GI\_other 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
* Yes
* Not sure
* Prefer not to answer

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Symtpom\_Neuro In the last 14 days, did you experience any of the following neurological symptoms?
Please select all that apply.

* ⊗None
* Headaches
* Loss of balance
* Slurred speech
* New confusion
* Unusual shivering or shaking
* Loss of smell
* Loss of taste
* Any tingling/numbness/swelling in hands or feet
* Seizures
* ⊗Prefer not to answer

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Symptom\_Neuro\_Other Are these symptoms consistent with any chronic neurological conditions you have, such as migraines, stroke, or other similar chronic conditions?

* No
* Yes
* Not sure
* Prefer not to answer

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Symptom\_Inflamm In the last 14 days, did you experience any of the following inflammatory symptoms?

* ⊗None
* Joint or any other unexplained pain
* Red or purple rash or lesions on your toes
* Unexplained rashes anywhere else
* Excessive sweating
* ⊗Prefer not to answer

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Symptom\_Inflamm\_othe 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
* Yes
* Not sure
* Prefer not to answer

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Symptoms\_Ill 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
* Bluish lips or face
* Change in or loss of appetite
* Chest pain
* Chills
* Cough
* Diarrhea
* Difficulty breathing
* Excessive sweating
* Fatigue (more than normal)
* Fever or feverish feeling
* Headaches
* Joint or any other unexplained pain
* Loss of balance
* Loss of taste
* Loss of smell
* Muscle aches (not due to exercise)
* New confusion
* Pinkeye or Conjunctivitis
* Red or purple rash or lesions on your toes
* Runny nose
* Seizures
* Shortness of breath
* Slurred speech
* Sore throat
* Stomach or abdominal pain
* Unexplained rashes anywhere else
* Unusual shivering or shaking
* Nausea or vomiting
* Wheezing
* ⊗Prefer not to answer

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symptom\_startdate When did these symptoms first start?
[Add Date Picker]

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End of Block: Symptom Block + Medication

Start of Block: Exposure

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Prev\_Diag Have you recovered from a previously diagnosed COVID-19 illness in the last 90 days?

* No
* Yes
* Prefer not to answer

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Prev\_exposure 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
* Yes, with COVID-19
* Yes, with flu
* ⊗Prefer not to answer

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Mask In the last 14 days, did you regularly 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
* Sometimes
* Yes, always
* Prefer not to answer

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Distance 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
* Sometimes
* Yes, always
* Prefer not to answer

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Food\_poison In the last 14 days, did you eat or drink anything that may have given you food poisoning?

* No
* Yes
* Prefer not to answer

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Flu\_shot Did you receive a flu shot/vaccine this season?

* No
* Yes
* Prefer not to answer

COVID\_vaccine Did you receive a vaccine for COVID-19?

* No
* Yes, both doses of a two-dose vaccine
* Yes, only the 1st dose of a two-dose vaccine
* Yes, one dose of a one-dose vaccine
* Prefer not to answer

COVID\_vaccine\_type Please specify the type of vaccine received:

* Pfizer/BioNTech
* Moderna
* Other
* Not sure or Prefer not to answer

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covid\_2dose\_specify Other, please specify:

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COVID\_vaccine\_type\_2 Please specify the type of vaccine received:

* Johnson and Johnson (J&J)
* Other
* Not sure or Prefer not to answer

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covid\_1dose\_specify Other, please specify:

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COVID\_vaccine\_date What date did you received the first dose or single dose of the COVID-19 vaccine?

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covid\_vaccine2\_date What date did you receive the second dose of the COVID-19 vaccine?

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Travel
In the last 14 days, did you travel to any states outside of Virginia?

* No
* Yes
* Prefer not to answer

states\_specify Please specify which states you traveled to (outside of Virginia) in the last 14 days:

* Alabama
* Alaska
* Arizona
* Arkansas
* California
* Colorado
* Connecticut
* Delaware
* District of Columbia
* Florida
* Georgia
* Hawaii
* Idaho
* Illinois
* Indiana
* Iowa
* Kansas
* Kentucky
* Louisiana
* Maine
* Montana
* Nebraska
* Nevada
* New Hampshire
* New Jersey
* New Mexico
* New York
* North Carolina
* North Dakota
* Ohio
* Oklahoma
* Oregon
* Maryland
* Massachusetts
* Michigan
* Minnesota
* Mississippi
* Missouri
* Pennsylvania
* Puerto Rico
* Rhode Island
* South Carolina
* South Dakota
* Tennessee
* Texas
* Utah
* Vermont
* Washington
* West Virginia
* Wisconsin
* Wyoming
* ⊗Prefer not to answer

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International
In the last 14 days, did you travel outside of the United States?

* No
* Yes
* Prefer not to answer

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countries\_specify Please specify which countries you visited in the last 14 days:

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End of Block: Exposure

Start of Block: Closure

covid\_thankyou Thank you for taking the time to complete this survey!
Next, please complete your at-home COVID test as soon as possible.

End of Block: Closure