C4R Questionnaire

Participant ID #: ☐☐☐☐☐☐☐

Interviewer ID: ☐☐☐☐☐☐ Date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

COVID-19 Survey

Greetings. Your responses to this survey will contribute to a better understanding of COVID-19 and the way it affects people like you.

If you have not had COVID-19, we expect that the survey will take 5 to 10 minutes. If you have been diagnosed with COVID-19, we will have some additional questions, so the survey may take up to 30 minutes or so. If you start the survey and need to continue later, you can scroll down and click the SUBMIT AND RETURN LATER button at the end – just be sure to record your return code.

Thank you so much for your participation in this important research.

Since your last COVID questionnaire

The last time we asked you about COVID-19 was [DATE]. At that time, you reported that you [HAD / had NOT] had COVID-19. The following questions will be about your experience since you completed the last COVID-19 questionnaire on [DATE].

COVID-19 TESTING

Since the last COVID-19 questionnaire, have you ever had any kind of test for COVID-19? Please include all types of tests that could show current or past infection (e.g., nose, spit, blood, PCR, antigen, or antibody tests).

- ○ Yes
- ○ No → **Skip to SELF REPORT**
- ○ Unsure →

If you'd like to provide some information on why you are unsure, please enter your comments here: _____

Skip to SELF REPORT

Why were you tested for COVID-19? *(Check all that apply)*

- ☐ I thought I might have had COVID-19
- ☐ I had symptoms of COVID-19
- ☐ Someone I spent time with had COVID-19
- ☐ A doctor told me to be tested for COVID-19
- ☐ A health department told me to be tested
- ☐ I was worried about COVID-19
- ☐ My employer or job required testing
- ☐ My school required testing
- ☐ I needed to be tested before a medical procedure
- ☐ I needed to be tested before or after traveling
- ☐ I needed to be tested to visit or provide care for a high risk person (e.g., older family member)
- ☐ Other: _____

Since the last COVID-19 questionnaire, have you ever had a test that showed you had COVID-19? Please include all types of tests.

- ○ Yes
- ○ No → **Skip to SELF REPORT**
- ○ Unsure →

If you'd like to provide some information on why you are unsure, please enter your comments here: _____

Skip to SELF REPORT

If previously reported COVID infection:
When was it that you had a test that showed you had COVID-19?

If no past record of COVID infection:
When was it that you first had a test that showed you had COVID-19?

Month: _____ Year: _____ (please estimate even if you are not sure)

What type of test was it? Pick one:

- ○ Nose ("nasal", "nasopharyngeal" swab)
- ○ Throat swab
- ○ Spit ("saliva") test
- ○ Blood test (including "blood draw," "dried blood spot," or "finger prick")
- ○ Other: _____

Would you be willing to send a copy of your COVID-19 results to the study?

- ○ Yes →
- ○ No

You are welcome to send your results in the following manner: [FILL IN COHORT PROCEDURES]

Skip to COVID-19 REINFECTION

COVID-19 SELF-REPORT

Since we know that some people may have had COVID-19 without having had a positive test, we want to ask a few more questions.

Since the last COVID questionnaire, do you think that you have had COVID-19?

- ○ Yes, definitely
- ○ Yes, I think so
- ○ Maybe → **Skip to HEALTHCARE PROVIDER**
- ○ No → **Skip to HEALTHCARE PROVIDER**

When did you think you had COVID-19?

Month: _____ Year: _____ (please estimate even if you are not sure)

Were you tested at that time?

- ○ Yes →
- ○ No

What type of test was it? Pick one:

- ○ Nose ("nasal", "nasopharyngeal" swab)
- ○ Throat swab
- ○ Spit ("saliva") test
- ○ Blood test (including "blood draw," "dried blood spot," or "finger prick")
- ○ Other: _____

Would you be willing to send a copy of your COVID-19 results to the study?

- ○ Yes
- ○ No

Why didn't you get tested for COVID-19 at that time? Check all that apply:

- ☐ I didn't know how/where to get tested
- ☐ It was hard to get tested (e.g., long lines)
- ☐ I was afraid to get tested
- ☐ I didn't think I needed to be tested
- ☐ I was worried about the cost
- ☐ I was worried about the consequences of being diagnosed with COVID-19
- ☐ A healthcare provider told me that a test was not necessary

HEALTHCARE PROVIDER

Since the last COVID questionnaire, 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. Close contact with someone who had COVID-19 ○ Yes ○ No

c. Other: _____

If "No" to TEST POSITIVE, SELF-REPORT, AND HEALTHCARE PROVIDER: Since we are interested in understanding the health effects of COVID-19, we would appreciate it if you would notify us if you are diagnosed with COVID-19. You are welcome to contact us in the following manner: _____. You are also welcome to send any COVID-19 test results in the following manner: [FILL IN COHORT PROCEDURES]

Then, **skip to COMMUNITY.**

COVID-19 RE-INFECTION (for participants with no past record of COVID-19)

You have reported that you know or think that you were infected with COVID-19 in [FILL IN MONTH, YEAR FROM ABOVE].

Has a healthcare provider ever told you that you may have gotten COVID-19 a second time, or that you have been "re-infected" with COVID019?

- ○ Yes
- ○ No ⟶ **Skip to HOSPITALIZATION**

Not counting your original infection, how many more times do you think you have been reinfected with COVID-19?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5

When do you know or think you were first re-infected with COVID-19?

Month: _____ Year: _____ (please estimate even if you are not sure)

At that time, what made you think you had been re-infected? Check all that apply:

- ☐ I had another test that showed that I had COVID-19
- ☐ I had symptoms of COVID-19 (fever, cough, trouble breathing)
- ☐ I had close contact with someone who had COVID-19
- ☐ Other: _____

This time, when you were re-infected, how did your symptoms compare to your first infection with COVID-19?

- ○ Worse than the first infection
- ○ About the same as the first infection
- ○ Better than the first infection
- ○ I had no symptoms

Allow more fields depending on the number of re-infections

Since we are interested in understanding the health effects of COVID-19, we would appreciate it if you would notify us if you are diagnosed again with COVID-19. You are welcome to contact us in the following manner: _____. You are also welcome to send any COVID-19 test results in the following manner: [FILL IN COHORT PROCEDURES]

COVID-19 HOSPITALIZATION

Since the last COVID-19 questionnaire, have you had an overnight stay in a hospital for any illness related to COVID-19?

- ○ Yes
- ○ No → **Skip to SYMPTOMS**
- ○ Unsure →

If you answer "unsure," we will not ask you any more questions about COVID-19 hospitalization. If you'd like to provide some information on why you are unsure, please enter your comments here:

_____

Skip to SYMPTOMS

If previously reported COVID infection:
Since the last COVID questionnaire, how many times have you been admitted to the hospital for COVID-19 or COVID-19 complications?

If no past record of COVID infection:
How many times have you been admitted to the hospital for COVID-19 or COVID-19 complications?

_____ times

If previously reported COVID infection:
Over this period, when was the first time you were hospitalized for COVID-19 or complications thereof?

If no record of COVID infection:
When was the first time you were hospitalized for COVID-19 or complications thereof?

Month: _____ Year: _____ (please estimate even if you are unsure)

Which hospital were you admitted to? (Name, City, State) _____

If previously reported COVID infection:
How many nights did you spend in the hospital?

If no record of COVID infection:
For the first hospital admission, how many nights did you spend in the hospital?

_____ nights

While in the hospital, did you have any of the following treatments?

	Yes	No	Don't know	# Days needed
Oxygen (by mask or nose)	○	○	○	_____
A breathing tube or ventilator	○	○	○	_____
"Intensive care unit" or ICU monitoring	○	○	○	_____
Dialysis	○	○	○	_____
Other: _____	○	○	○	_____

After this hospitalization, did you:

- ○ Return home?
- ○ Go to a nursing or rehabilitation facility?
- ○ Go to live in the home of family or a friend?
- ○ Other: _____

If more than one hospitalization:

When was the [FILL IN AS NEEDED, SECOND, THIRD, ETC] time you were hospitalized for COVID-19 or complications thereof?

Month: _____ Year: _____

Which hospital were you admitted to? (Name, City, State) _____

How many nights did you spend in the hospital? _____ nights

While in the hospital, did you have any of the following treatments?

	Yes	No	Don't know	# Days needed
Oxygen (by mask or nose)	○	○	○	_____
A breathing tube or ventilator	○	○	○	_____
"Intensive care unit" or ICU monitoring	○	○	○	_____
Dialysis	○	○	○	_____
Other: _____	○	○	○	_____

After this hospitalization, did you:

- ○ Return home?
- ○ Go to a nursing or rehabilitation facility?
- ○ Go to live in the home of family or a friend?
- ○ Other: _____

COVID-19 SYMPTOMS

If previously reported COVID infection:

When you knew or thought that you had COVID-19 in [FILL IN DATES FROM ABOVE REGARDING INFECTION], did you have any symptoms?

If no past record of COVID infection:

When you knew or thought that you had COVID-19 in [FILL IN DATES FROM ABOVE REGARDING FIRST INFECTION], did you have any symptoms?

- ○ Yes
- ○ No ⟶ **Skip to RECOVERY**

Overall, when you COVID-19 symptoms were at their worst, did they interfere with (prevent you from going about) your daily activities?

- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit
- ○ Very much

If participant previously reported COVID infection:

How did your symptoms compare to your first infection with COVID-19, which you reported on [DATE OF LAST QUESTIONNAIRE]?

- ○ Worse than the first infection
- ○ About the same as the first infection
- ○ Better than the first infection
- ○ I had no symptoms

If previously reported COVID infection:

When you had COVID-19 in [DATE], did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

If no past record of COVID infection:

When you had COVID-19, did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

Symptom	**Yes**	**If yes:** **How many days did you have the symptom?**	**If yes:** **Do you still have the symptom?**
Fever	☐		○ Yes ○ No
Shortness of breath (trouble breathing)	☐		○ Yes ○ No
Cough	☐		○ Yes ○ No
Chest pain	☐		○ Yes ○ No
Abdominal pain	☐		○ Yes ○ No
Nausea	☐		○ Yes ○ No
Vomiting	☐		○ Yes ○ No
Diarrhea	☐		○ Yes ○ No
Body or muscle aches	☐		○ Yes ○ No
Weakness or fatigue	☐		○ Yes ○ No
Runny or dripping nose	☐		○ Yes ○ No
Chills	☐		○ Yes ○ No
Headache	☐		○ Yes ○ No
Sore throat	☐		○ Yes ○ No
Stuffy nose (nasal congestion)	☐		○ Yes ○ No

(continued)

If previously reported COVID infection:

When you had COVID-19 in [DATE], did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

If no past record of COVID infection:

When you had COVID-19, did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

Symptom	**Yes**	**If yes:** **How many days did you have the symptom?**	**If yes:** **Do you still have the symptom?**
New loss of taste or smell	☐		○ Yes ○ No
Confusion	☐		○ Yes ○ No
Trouble sleeping	☐		○ Yes ○ No
Conjunctivitis	☐		○ Yes ○ No
Skin changes	☐		○ Yes ○ No
Other: _____	☐		○ Yes ○ No

COVID-19 RECOVERY

If previously reported COVID infection:

Following your COVID-19 infection in [FILL IN DATES FROM ABOVE REGARDING FIRST INFECTION AND REINFECTION], would you say you are completely recovered from COVID-19 now?

If no past record of COVID infection:

Following your COVID-19 infection in [FILL IN DATES FROM ABOVE REGARDING INFECTION], would you say you are completely recovered from COVID-19 now?

- ○ Yes → How long did it take for you to recover? _____ months _____ days
- ○ No

At this time, do you have any of the following symptoms? *(Check all that apply)*

- ☐ Problems with your memory
- ☐ Problems with paying attention
- ☐ Problems with your appetite
- ☐ Problems with feeling lightheaded
- ☐ Trouble sleeping
- ☐ Periods of racing heart rate
- ☐ Inability to exercise at pre COVID level
- ☐ Inability to return to work or school (if you were working or in school pre-COVID)
- ☐ Inability to return to your usual pre-COVID activities
- ☐ Feeling weak, tired and/or sick 24-48 hours after physical activity
- ☐ Other: _____

How worried are you that COVID-19 infection is going to have a long-term effect on your health?

- ○ Not at all worried
- ○ A little worried
- ○ Very worried

Is there anything else you'd like to share about your COVID-19 recovery experience?

_____