Q (multi-select): Have you EVER been exposed to someone with documented or suspected COVID-19 infection (such as co-workers, family members, or others)? Please check all that apply.

a. Yes, documented COVID-19 cases only
b. Yes, suspected COVID-19 case only
c. Yes, both documented and suspected COVID-19 cases
d. Not that I know of

Q (select one): In general, do you have any health problems that require you to stay at home?
1. No
2. Yes

Q (select one): Do you need someone to help you on a regular basis?
1. No
2. Yes

Q (select one): If you need help, can you count on someone close to you?
1. No
2. Yes

Q (select one): Do you regularly use a cane, walker or wheelchair to get about?
1. No
2. Yes

Q (select one): In general, do you have any health problems that require you to limit your activities?
1. No
2. Yes

If answered "female" previously show:

Q (select one): Are you currently having periods?
1. I've never had periods
2. I'm currently having periods
3. I've stopped having periods
4. I'm pregnant
5. I'm not currently having periods
6. Prefer not to say
7. Other

If currently having periods,

Q (select one): Do you periods usually occur?
1. regularly every 3-6 weeks
2. Regularly, but less often than every 6 weeks
3. At irregular intervals

If I've stopped having periods

Q (text response): At what age did your periods stop?

If pregnant,

Q (text response): How many weeks pregnant are you?

Q (select one): Are you taking any of the following forms of hormone treatment?
1. No
2.Combined oral contraceptive pill
3. Progesterone only pill
4. Mirena or other hormone coil
5. Depot injection or implant
6. Hormone replacement therapy
7. Estrogen hormone therapy for gender transitioning
8. Testosterone hormone therapy
9. Prefer not to say
10. Other

Q (select one): Do you have heart disease?
1. No
2. Yes

Q (select one): Do you have diabetes?
1. No
2. Yes

Q (select one): Do you have hayfever (seasonal allergies)?
1. No
2. Yes

Q (select one): Do you have eczema?
1. No
2. Yes

Q (select one): Do you have asthma?
1. No
2. Yes

Q (select one): Do you have lung disease?
1. No
2. Yes

Q (select one): Do you smoke?
1. Never
2. Not currently
3. Yes

If "Not currently " show:

Q (text entry): How many years since you last smoked?

Q (select one): Do you have kidney disease?
1. No
2. Yes

Q (select one): Are you living with cancer?
1. No
2. Yes

If "Yes" show:

Q (text entry): What type of cancer do you have?

Q (select one): Are you on chemotherapy or immunotherapy for cancer?
1. No
2. Yes

Q (select one): Do you regularly take immunosuppressant medications (including steroids, methotrexate, biologic agents)?
1. No
2. Yes

Q (select one): Do you regularly take aspirin (baby aspirin or standard dose)?
1. No
2. Yes

Q (select one): Do you regularly take “NSAIDs” like ibuprofen, nurofen, diclofenac, naproxen?
1. No
2. Yes

Q (select one): Are you regularly taking any blood pressure medications?
1. No
2. Yes

If "Yes" show:

Q (select one): Are you regularly taking any blood pressure medications ending in “-pril”, such as enalapril, lisinopril, captopril, ramipril?
1. No
2. Yes

Q (select one): Are you regularly taking blood pressure medications ending in “-sartan”, such as losartan, valsartan, irbesartan?
1. No
2. Yes

Q (multi-select): Have you been taking any vitamins or other supplements regularly for more than 3 months? Regularly means more than 3 times a week on average. Select all that apply. We are exploring the possible effects of vitamin supplements on COVID infection.

a. No
b. Vitamin C
c. Vitamin D
d. Omega-3 or Fish Oil
e. Zinc
f. Garlic
g. Probiotics
h. Multi-vitamins and minerals
i. Other, please specify
j. Prefer not to say

If “Other” show:

Q (text entry): Please specify the vitamins or supplements.

Q (select one): If you know it, what is your blood group?
1. A
2. B
3. AB
4. O
5. I don’t know my blood group for certain
6. Prefer not to say