Active Seronet Recruitment

Record ID

_____

Participant ID

_____

Which language would you prefer to use?

¿Qué idioma prefiere usar?

◯ English
◯ Español

Demographic Information

Today's date

_____

First name

_____

Last name

_____

Your date of birth

_____
((mm/dd/yyyy))

Do you consider yourself.....?

☐ Black
☐ African American
☐ Chinese American
☐ Indian American
☐ Filipino American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ White
☐ More than one - Mix
☐ Other

Please explain other

_____

Do you consider yourself.....?

_____

What is your gender?

◯ Male
◯ Female
◯ Non-binary
◯ Other - please specify

Other - please specify

_____

Are you Latino or Hispanic?

◯ Yes
◯ No

What is the highest grade or level of school you have completed or the highest degree you have received?

◯ Primary/elementary school
◯ High school (or equivalent)
◯ College
◯ Advanced degree
◯ Other - please specify

Other - please specify

_____

Your phone number

_____

(Your contact information is collected solely for this research study and will not be shared with anyone outside of our team.)

Your email

_____

(Your contact information is collected solely for this research study and will not be shared with anyone outside of our team.)

Age

_____

Symptoms and Exposures

Have you ever tested positive for the virus that causes COVID-19 (SARS-CoV-2)?

◯ Yes
◯ No

Other interval of testing

_____

How often are you tested for the virus that causes COVID-19?

◯ Never
◯ Weekly
◯ Monthly
◯ When needed
◯ Other - please specify

Other - please specify

_____

How many positive COVID-19/SARS-CoV-2 tests have you had?

_____

When was the sample that turned out positive collected? (MM/DD/YYYY)

_____

(If you don't know the exact date you tested positive, then please indicate the month and year.)

What symptoms did you experience in association with the positive test?

- ☐ Fever
- ☐ Fatigue
- ☐ Cough
- ☐ Loss of appetite
- ☐ Body aches
- ☐ Shortness of breath
- ☐ Mucus or phlegm
- ☐ Sore throat
- ☐ Headache
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Chills, sometimes with shaking
- ☐ Loss of smell or taste
- ☐ Purple fingers or toes (Chilblains)
- ☐ A rash on skin, or discolouration of fingers or toes
- ☐ Loss of speech or movement
- ☐ Conjunctivitis
- ☐ Unusual weakness
- ☐ Unexplained muscle aches
- ☐ Other Symptoms
- ☐ None

Other Symptoms

_____

How many days were you sick for?

_____

If you had to rate your overall well-being while sick where would it fall between 1 and 10? (10 being the most sick/worst symptoms)

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

Were you hospitalized because of these symptoms?

- ◯ Yes
- ◯ No

Have you had a positive test for SARS-COV-2 antibodies (serological/blood test for COVID-19)? Not counting the one being done today.

- ◯ Yes
- ◯ No

Was the antibody test done as part of a scientific study or was it by personal or clinical request?

- ◯ Research Study
- ◯ Personal (for example clinical reason)
- ◯ Other

Other reason

_____

Name of research study

_____

When was the last time you had a positive antibody test? (mm/dd/yyyy)

_____
(If you don't know the exact date then please indicate the month and year.)

When was the antibody sample taken that came back positive? (mm/dd/yyyy)

_____
(If you don't know the exact date then please indicate the month and year.)

What symptoms did you experience in association with the positive antibody test?

- ☐ Fever
- ☐ Fatigue
- ☐ Cough
- ☐ Loss of appetite
- ☐ Body aches
- ☐ Shortness of breath
- ☐ Mucus or phlegm
- ☐ Sore throat
- ☐ Headache
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Chills, sometimes with shaking
- ☐ Loss of smell or taste
- ☐ Purple fingers or toes (Chilblains)
- ☐ A rash on skin, or discolouration of fingers or toes
- ☐ Loss of speech or movement
- ☐ Conjunctivitis
- ☐ Unusual weakness
- ☐ Unexplained muscle aches
- ☐ Other Symptoms
- ☐ None

Other Symptoms

_____

How many days were you sick for?

_____

If you had to rate your overall well-being while sick where would it fall between 1 and 10? (10 being the most sick/worst symptoms)

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

Were you hospitalized because of these symptoms?

- ◯ Yes
- ◯ No

Do you think you may have had COVID-19 even if not confirmed by a test?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

How many times do you think you may have COVID-19?

_____

When do you think you had COVID-19 (MM/DD/YYY)?

_____
(If you don't know the exact date, then please indicate the month and year.)

What symptoms did you experience?

- ☐ Fever
- ☐ Fatigue
- ☐ Cough
- ☐ Loss of appetite
- ☐ Body aches
- ☐ Shortness of breath
- ☐ Mucus or phlegm
- ☐ Sore throat
- ☐ Headache
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Chills, sometimes with shaking
- ☐ Loss of smell or taste
- ☐ Purple fingers or toes (Chilblains)
- ☐ A rash on skin, or discolouration of fingers or toes
- ☐ Loss of speech or movement
- ☐ Conjunctivitis
- ☐ Unusual weakness
- ☐ Unexplained muscle aches
- ☐ Other Symptoms
- ☐ None

Other symptoms

_____

How many days were you sick for?

_____

If you had to rate your overall well-being while sick where would it fall between 1 and 10? (10 being the most sick/worst symptoms)

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

Were you hospitalized because of these symptoms?

- ◯ Yes
- ◯ No

If you had COVID-19, are you feeling better or do you have lingering health concerns?

- ◯ I am feeling better
- ◯ I am not back to 100%
- ◯ I believe I have long COVID-19 symptoms (health problems 4 or more weeks after first being infected with the virus that causes COVID-19).
- ◯ I never had COVID-19

Before the COVID-19 pandemic were you a smoker or a vaper?

- ◯ Yes - smoker
- ◯ Yes - vaper
- ◯ No

Prior to the COVID-19 pandemic, did you have any of the following medical conditions?	☐ Alcoholism ☐ Diabetes type I ☐ Diabetes type II ☐ Obesity ☐ Chronic kidney disease ☐ Dementia ☐ Alzheimer's disease ☐ Chronic liver disease ☐ Other Chronic respiratory disease (e.g., COPD, Emphysema) (specify) ☐ Asthma ☐ Chronic oxygen requirement ☐ Coronary artery disease ☐ Epilepsy ☐ Multiple sclerosis ☐ Other Chronic Neurological condition (specify) ☐ Hepatitis ☐ Hypertension ☐ Congestive heart failure ☐ Cancer ☐ Immune deficiency/HIV/AIDS ☐ Autoimmune/Immunocompromised condition ☐ Psychological/psychiatric condition ☐ Substance Use Disorders ☐ Other chronic diseases (specify) ☐ None
Other Chronic respiratory disease (e.g., COPD, Emphysema) (specify)	_____
Other Chronic Neurological condition (specify)	_____
Other chronic diseases (specify)	_____
Vaccination	
Have you been vaccinated against influenza in the past 5 years?	◯ Yes ◯ No
Have you been vaccinated against the virus that causes COVID-19?	◯ Yes ◯ No
Have you been confirmed or suspected to have COVID-19 prior to vaccination?	◯ Yes ◯ No
When did you get your first vaccine dose? (mm/dd/yy)	_____ (If you don't know the exact date, then please indicate the month and year.)
Which vaccine did you get?	◯ Moderna ◯ Pfizer ◯ Johnson & Johnson ◯ Other
Other vaccine	_____

Did you experience vaccine-associated symptoms with your first shot?	☐ None ☐ Arm soreness ☐ Arm swelling ☐ Fever ☐ Chills ☐ Fatigue ☐ Nausea ☐ Swollen lymph nodes ☐ Muscle pain ☐ Headache ☐ Other body aches ☐ Other
Other symptoms	_____
How long did the symptoms persist?	◯ 24 hrs ◯ 48 hrs ◯ Other
Other	_____
If you had to rate your overall well-being while experiencing the vaccine-associated symptoms for the first dose, where would it fall between 1 and 10? (10 being the most sick/worst symptoms)	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
Were you hospitalized because of these symptoms?	◯ Yes ◯ No
Did you get your second vaccine dose?	◯ Yes ◯ No ◯ My vaccine only requires 1 shot
When did you get your second vaccine dose? (mm/dd/yy)	_____ (If you don't know the exact date, then please indicate the month and year.)

Would you get an approved COVID-19 vaccine if offered to you?	◯ Yes ◯ No ◯ I would like more information on the vaccine before making that kind of decision
Why would you not want to get vaccinated?	_____
Have you had a booster?	◯ Yes ◯ No
Which vaccine type were you boosted with?	◯ Moderna ◯ Pfizer ◯ Johnson & Johnson ◯ Other
Other booster type	_____

When did you get the booster? (mm/dd/yy)	_____ (If you don't know the exact date, then please indicate the month and year.)
Can someone from this study contact you in the future to ask you other COVID-19-related questions?	◯ Yes ◯ No
If you do not mind, please indicate why you prefer not to be contacted by a study team member.	_____
Please feel free to leave any message for the study team.	_____
Please make sure to submit the survey. Thank you very much for your time and help!	