Supplemental Appendix 1, Baseline Survey

General Information:

1. Age
2. Postal code: first three digits
3. Household information: How many individuals are in your household? What are their ages?
4. What Ethnic group best describes you: European, South Asian, East/Southeast Asian, West Central Asian/ Middle Eastern, West Indian/ Caribbean, African, Latin/ Central/ South American, Aboriginal/ Indigenous, Multi-Ethnic, Canadian/ American, Other
5. What group best describes your ancestry? White/Black/Hispanic/East Asian/Pacific Islander/South Asian, Middle Eastern/Central Asian/Other
6. Any other HCWs in the household? Yes / No
7. Years of employment
8. Gender: Male, female, prefer not to specify
9. Number of shifts (or days worked) in the past 14 days
10. Work Place: ER/Urgent Care, ICU, Inpatient, Outpatient, Surgery/Perioperative care, COVID-19 Assessment Centre, Short stay/Dialysis, Other
11. Role:
    a. Healthcare care professionals (physicians, nurses, nurse practitioner)
    b. Allied health worker (phlebotomists, respiratory therapists, social workers, dieticians, diagnostic imaging technician/ physicians physiotherapists, occupational therapists, and dentistry)
    c. Auxiliary (environmental services personnel, patient transport/ porter, laboratory personnel and ward clerical workers)
12. What PPE do you wear for all patient encounters (i.e for asymptomatic patients not in other precautions)? Check all that apply – face mask, N95 respirators, gown, gloves, eye protection (goggles or face mask)
13. What PPE do you wear for the routine care of suspect or confirmed COVID-19 patients? Check all that apply - face mask, N95 respirators, gown, gloves, eye protection (goggles or face mask)

Health Information:

14. Self-reported weight
15. Self-reported height
16. Current smoker (vaping included): Yes / No
17. Pregnancy: Yes / No / Unknown; If yes, specify trimester: first, second, third, unknown
18. Underlying Medical Conditions:
    a. Cancer: yes / no
    b. Diabetes: yes / no

i. Has a doctor ever told you that diabetes has affected your eyes; or that you have diabetic retinopathy or have you ever received laser eye therapy for your diabetes?

ii. Are you currently taking insulin? Y/N

iii. Do you currently take diabetes pills (oral agents or oral hypoglycemic agents) to lower your blood sugar. Y/N

c. Immune Deficiency/ HIV: yes / no

i. Have you ever received a transplant of an organ other than kidney (e.g. bone marrow, heart, lung, liver or pancreas)?

d. Heart disease: yes / no

i. Has a doctor or other health professional ever told you that you have coronary/ artery disease (heart attack, angina)? Y/N

ii. Have you ever had prior revascularization of your heart/ blood vessels by balloon angioplasty? Y/N

iii. Have you ever had a prior revascularization of your heart /blood vessels by coronary stenting? Y/N

iv. Have you ever had a prior revascularization of your heart blood vessels by coronary bypass surgery? Y/N

v. Has a doctor or other health professional ever told you that you have heart failure? Y/N

vi. Has a doctor or other health professional ever told you that you have atrial fibrillation or atrial flutter (an irregular heart rhythm)? Y/N

vii. Have you ever had any procedure to open the blood vessels of the neck (carotid endarterectomy)? Y/N

viii. Has a doctor or other health professional ever told you that you have hypertension or high blood pressure? Y/N

e. Asthma (requiring medication): yes / no

i. Have you ever been hospitalized for your asthma? Y/N

ii. Do you use an inhaler? Y/N

f. Chronic lung disease (non-asthma): yes / no

i. Have you ever been hospitalized for COPD? Y/N

ii. Do you use an inhaler? Y/N

g. Chronic liver disease: yes / no

i. Has a doctor or other health professional ever diagnosed or treated you for hepatitis (B or C) infection? Y/N

h. Chronic hematologic (blood) disease (e.g. sickle cell disease, hemoglobinopathies): yes / no

i. Chronic kidney disease: yes / no

j. Chronic neurological disease / impairment: yes / no

   i. Were you ever told by a physician that you had a stroke? Y/N

   ii. Were you ever told by a physician that you had a transient ischemic attack (TIA), ministroke? Y/N

k. Inflammatory Diseases: Yes/No

l. Has a doctor or other health professional ever diagnosed or treated you for rheumatoid arthritis? Y/N

m. Has a doctor or other health professional ever diagnosed or treated you for gout? Y/N

n. Other pre-existing condition: yes / no, if yes, specify

19. Medications

a. Have you ever had a vaccination for Covid-19?

   i. If yes, how many doses?

   ii. Please indicate the date each dose was received

   iii. Please indicate the vaccine manufacturer if able

b. Do you currently take prescribed medication for your hypertension or high blood pressure? Y/N

c. Do you currently take prescribed medication for your high blood cholesterol?

d. Have you ever received treatment with immunosuppressive drugs such as Cyclophosphamide, Cytoxan, Steroids, Prednisone, Cellcept, or Cyclosporine within the past 6 months. Y/N

e. Any other medication? Y/N. Specify.

20. Any illness or symptoms in the last 3 months: yes / no, if yes, specify

21. Have you ever had any specimens collected for COVID-19 testing (ie NP Swab, Saliva, etc)?: yes / no; if yes, was it positive? Yes / no; if yes, specify date

22. Any history of blood transfusion or immunoglobulin in the last year? Yes / No; if yes, specify date

Exposure history:

23. Any sick contacts in the household in the last 3 months? Yes / no; if yes, what are the ages of sick contacts? have they been tested for COVID-19? Yes/no; if yes, was the result positive? Yes / no / unknown

24. Have you provided direct care to a patient with COVID-19? Yes / No; if yes, how often? Daily, 2-3 times per week, weekly, rarely

25. If yes to 24, have you had any unprotected exposures (i.e within 2 m of the patients without appropriate PPE)? Yes / No; if yes, please specify date(s) and describe exposure(s)

26. If yes to 24, did you perform any aerosol generating medical procedures? (link to PHO list to specify) Yes / No, if yes; list procedure

27. Have you worked on a unit where a COVID-19 outbreak has been declared (during the outbreak period)? if yes, how often? Daily, 2-3 times per week, weekly, rarely

28. Have you been diagnosed by SARS or MERS? Yes / No; if yes, please specify date:

29. Have you been contacted by Public Health to indicate you may have been exposed to someone with COVID-19? Yes / No

30. Have you ever been notified by the COVID Alert App that you may have been exposed to someone with COVID-19?

31. In the last two weeks, how often have you left the house per week (excluding work)? 1 time, 2-4 times, 3-5 times, > 5 times

32. When leaving the house, did you adhere to physical distancing (staying > 2 m away from non-household contacts); always, most of the time, sometimes, never

33. When leaving the house, did you wear a facemask? Always, most of the time, sometimes, never

34. Any travel in the last 4 months? Yes / No, specify country (drop down list) and dates

35. Any other important information we should know related to COVID-19 exposure or risk?