

## Core Survey: Resp Illness Other Screens

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**How are YOU? A Survey of Patient Health During the COVID-19 Pandemic** The COVID pandemic has changed the way we live life in many ways. Some include having had the infection itself, or having a respiratory illness like COVID-19, or just trying to stay healthy during a time when social distancing and closed businesses are in effect. This survey is designed to help us better understand the impact of the COVID pandemic on the health of our Michigan Medicine patients. We are specifically interested in the experiences of our patients who have been diagnosed with respiratory illnesses. We are interested in how your health may have changed or been impacted by the COVID pandemic over the last 4 months. This survey should take approximately 15-20 minutes of your time. This survey will not be linked to your medical records. We will protect the confidentiality of the information you share. Only study team members will have access to the data and this information will not be linked to your identity. All data will be stored on University of Michigan password-protected servers. Thank you for your participation, the Family Medicine Study Team. If you have questions about the survey, please call Dr. *[name redacted]* at *[phone number redacted]*. If you agree to take this survey, please click the next button at the bottom of your screen.

In what ways has the COVID pandemic impacted your life? **(Select all that apply)**

- Physical health (1)
- Mental health (2)
- Ability to engage in healthy behaviors (e.g. exercise, healthy diet) (3)
- Ability to seek needed routine medical care (e.g. doctor appointments, prescription medication) (4)
- Employment/income (5)
- Education (6)
- Social life (7)
- Community engagement (e.g. volunteering, advocacy) (8)
- Caregiver responsibilities (e.g. children, elderly parents) (9)
- Other (please specify) (10) \_\_\_\_\_
- None of the above (i.e. it has not impacted my life) (11)

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Page Break

V14

**Over the past 4 months**, how much would you say your overall health has changed?

- It has not changed at all (1)
- It's changed a little (2)
- It's changed a moderate amount (3)
- It's changed a lot (4)

*Skip To: Q1 If Over the past 4 months, how much would you say your overall health has changed? = It has not changed at all*

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Page Break

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V15

Has this change resulted in you being in better health or worse health overall?

- Better health now than 4 months ago (1)
  - Worse health now than 4 months ago (2)
  - My health has changed but overall is not better or worse (just different) than it was 4 months ago (3)
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Page Break

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V16

How much of this change do you attribute to the COVID pandemic and its impact on society and your day to day life?

- None (1)
- A little (2)
- Some (3)
- A moderate amount (4)
- A lot (5)
- Almost all (6)

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Page Break

V53

The COVID pandemic has changed the way healthcare is delivered in many places. For some access to care has been difficult and for others important but non urgent care has been delayed.

Did you try to contact your primary care provider during the last 4 months?

- Yes (1)
- No (2)
- Unsure (3)

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Page Break

Display This Question:

If The COVID pandemic has changed the way healthcare is delivered in many places. For some access to... =  
Yes

Or The COVID pandemic has changed the way healthcare is delivered in many places. For some access to... =  
Unsure

What type of options did you have for visits? **(Select all that apply)**

Video visits (1)

Phone visits (2)

Patient portal (3)

In-person visits (6)

Unsure (5)

Other (please specify) (4) \_\_\_\_\_

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V61

Important preventive health care includes screening tests for cancer. Most cancer screens are done in the doctor's office or through a blood draw. However, for some cancers such as colorectal cancer and cervical cancer, there are home-based screening options. If your doctor told you that you were currently due for **colon cancer screening**, would you be willing to get screened at home by receiving a self-sampling kit in the mail and then mailing back a stool sample to be tested? (All instructions on how to use the kit and a phone number to contact if you have any questions would be included).

- No, I would rather not get screened at all (1)
- No, I would prefer to delay my screening until I could return to my doctor's office (2)
- Maybe (3)
- Yes, but I would only choose this option if my doctor was not offering the usual screenings at the office (4)
- Yes, and I would choose this option even if my doctor was offering the usual screenings at the office (5)

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Page Break

V62

Have you had any symptoms of COVID-19?

- Yes (1)
- No (2)
- Unsure (3)

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Page Break

*Display This Question:*

*If Have you had any symptoms of COVID-19? = Yes*

*Or Have you had any symptoms of COVID-19? = Unsure*

JS

v63

Please provide an estimated date for when your COVID-19 symptoms **began**:

	Month	Day	Year
Please Select: (1)	▼ January (1 ... December (12)	▼ 1 (1 ... 31 (31)	▼ 1900 (1 ... 2049 (150)

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Page Break

V69

Have you been tested for COVID-19?

Yes (1)

No (2)

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Page Break

*Display This Question:*

*If Have you been tested for COVID-19? = Yes*

JS

Please provide a date for when you received the COVID-19 test:

	Month	Day	Year
Please Select: (1)	▼ January (1 ... December (12)	▼ 1 (1 ... 31 (31)	▼ 1900 (1 ... 2049 (150)

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Page Break



Display This Question:

If Have you been tested for COVID-19? = Yes

Did you test positive for COVID-19?

Yes (1)

No (2)

Page Break

Display This Question:

If Have you had any symptoms of COVID-19? = Yes

Or Have you had any symptoms of COVID-19? = Unsure

JS

Please provide an estimated date for when your COVID-19 symptoms **resolved**:

	Month	Day	Year
Please Select: (1)	▼ January (1 ... December (12)	▼ 1 (1 ... 31 (31)	▼ 1900 (1 ... 2049 (150)

Page Break

*Display This Question:*

*If Have you had any symptoms of COVID-19? = Yes*

*Or Have you had any symptoms of COVID-19? = Unsure*

Were you hospitalized for your symptoms?

Yes (1)

No (2)

*Skip To: End of Block If Were you hospitalized for your symptoms? = No*

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Page Break

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*Display This Question:*

*If Were you hospitalized for your symptoms? = Yes*

How many days were you in the hospital?

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*Display This Question:*

*If Were you hospitalized for your symptoms? = Yes*

Were you intubated?

Yes (1)

No (2)

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Page Break

*Display This Question:*

*If Were you hospitalized for your symptoms? = Yes*

Following your hospitalization, did you have any follow-up meeting(s) with your primary care provider?  
**(Select all that apply)**

In-person (1)

Video visit (2)

Patient portal (3)

Phone visit (4)

I did not have any follow-up (6)

Other (please describe) (5) \_\_\_\_\_

End of Block: Default Question Block

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