COVIDGene Questionnaire

Please complete the survey below.

Thank you!

Name of Interviewer: Last, First

_____

Date

_____

Case or household member?

◯ Case
◯ Household member

Script for interviewer: We would like to ask you some questions to help us better understand symptoms and behaviors from your household related to the novel coronavirus (COVID-19) pandemic.
The interview will take us approximately 10 minutes, depending on your experiences.

Full Name: Last, First

_____

Please provide a complete mailing address.
(repeat address to person after typing in)

_____

What is your current age?

_____

What is your gender?
(You can let them tell you--if they need a prompt or if you need clarify you can read).

- ◯ Male/Man
- ◯ Female/Woman
- ◯ Trans Male/Trans Man
- ◯ Trans Female/Trans Woman
- ◯ Genderqueer/Gender Non-conforming
- ◯ Different identity (please specify)
- ◯ Refuse to answer

2a Gender_Other: Please specify

_____

2 Race (Select all that apply)

- ☐ White
- ☐ Black/African American
- ☐ Asian American
- ☐ Native American/American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other
- ☐ Refuse to answer

2a Race: Other (please specify)

_____

3 Are you Hispanic, Latino, or of Spanish origin?

- ◯ Yes
- ◯ No

4 Were you born in the United States?

- ◯ Yes
- ◯ No

5 What is the highest level of education you have completed?

- ◯ Never attended school
- ◯ Grades 1-8
- ◯ Grades 9-11/Some high school
- ◯ Grade 12/Completed high school or GED
- ◯ Some college, Associates degree, or Technical degree
- ◯ Bachelor's degree
- ◯ Any post graduate studies
- ◯ Don't know
- ◯ Refused

6	Which of the following options best describes your activities related to work, school or home before the novel coronavirus (COVID-19) pandemic may have affected your work (before March 1, 2020)? This includes both formal and informal employment. Were you: (Select all that apply)	☐ Employed full-time (40 hours per week) ☐ Employed part-time (Less than 40 hours per week) ☐ Self-employed ☐ Full-time student ☐ Part-time student ☐ Unemployed ☐ Unable to work for health reasons ☐ Stay at home spouse ☐ Stay at home parent/guardian for child or sibling ☐ Active military ☐ Retired ☐ Other (specify)
6a	Employment_Other: Please specify	_____
	Are any of the following your occupation?	☐ Health Care Worker Hospital ☐ Health Care Worker Community ☐ Nursing Home ☐ Teacher K-12 ☐ Fire/Police/State Trooper/EMT ☐ Military ☐ Transportation (bus, train, light rail, uber, etc) ☐ Hotel Staff ☐ Cleaning (office/home) ☐ Military ☐ NONE
8	What was your household income last year (in 2019) from all sources before taxes? This includes all income from both formal and informal employment.	◯ Monthly income: $0 to $833; Yearly income: $0 to $9,999 ◯ Monthly income: $834 to $1,250; Yearly income: $10,000 to $14,999 ◯ Monthly income: $1,251 to $2,082; Yearly income: $15,000 to $24,999 ◯ Monthly income: $2,083 to $2,916; Yearly income: $25,000 to $34,999 ◯ Monthly income: $2,917 to $4,167; Yearly income: $35,000 to $49,999 ◯ Monthly income: $4,168 to $6,249; Yearly income: $50,000 to $74,999 ◯ Monthly income: $6,250 or more; Yearly income: $75,000 or more ◯ Don't Know ◯ Refuse to Answer
9	Including yourself, how many people depend on this income?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 or more ◯ Don't know ◯ Refuse to answer

10 Are you currently a caregiver for a dependent/dependents in your home? A dependent is anyone who relies on you for help with activities of daily living, including children under the age of 18 years, anyone over the age of 70 years, or someone with a chronic disease or disability.

◯ Yes
◯ No

Section 2: Household.

I would now like to ask you some questions about your household and who lives in it.

Who lives in the same house as you. Please check all that apply.

If a relative is listed please only consider biologic relatives versus adopted or other familial relationships. You can clarify this by saying some people are family but they are not related to you by blood. When you say a relative name let me know if that is a blood relative. Otherwise I can list them in another way.

- ☐ Spouse
- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ BIologic Child
- ☐ Other non-biologic family member
- ☐ Nephew
- ☐ Niece
- ☐ Aunt
- ☐ Uncle
- ☐ Brother
- ☐ Sister
- ☐ Cousin
- ☐ Friend
- ☐ Housemate
- ☐ Grandchild

Please list the names of everyone in your household and their relation to you. Include and note any step- or half-relations. For relatives not in your immediate family who live in the household, please include whether they are your maternal or paternal relative.

_____

11 In which type of space do you live?

- ◯ Single family home
- ◯ Rowhome/townhome (single family occupancy)
- ◯ Rowhome/townhome (multiple family occupancy)
- ◯ Condominium
- ◯ Apartment
- ◯ Other (please specify)

11a Livingspace_Other: Please specify

_____

12 Including yourself, how many people (including children) use/currently share your kitchen or living space?

_____

12a How many bedrooms are in the place where you stay?

_____

12b How many bathrooms are in the place where you stay?

_____

Was anyone else in your household also sick before or after you with COVID-19 symptoms?

- ◯ Yes
- ◯ No

Did anyone else in the household take a COVID-19 test before or after your test?

- ◯ Yes
- ◯ No

Section 3: Symptoms

16 Do you have seasonal allergies?
- ◯ Yes
- ◯ No

In the two weeks prior to testing positive for COVID-19 did you have any symptoms?
- ◯ Yes
- ◯ No

In the two weeks post testing positive for COVID-19 did you have any symptoms?
- ◯ Yes
- ◯ No

13 In the two weeks prior to your testing did YOU have any of these symptoms?
- ☐ Fever > 100.4F or > 38C
- ☐ Fever but do not know exact temperature (no thermometer)
- ☐ New or worsening cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Congestion
- ☐ Shortness of breath
- ☐ Chills/repeated shaking with chills
- ☐ Lack of energy or general tired feeling
- ☐ Loss of appetite, like you just haven't been hungry
- ☐ tightness, or pressure in chest
- ☐ Feeling sick to your stomach or vomiting
- ☐ Diarrhea
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ having hallucinations, altered consciousness
- ☐ Loss of ability to smell
- ☐ Loss of ability to taste
- ☐ No Symptoms

13 In the two weeks after your testing did YOU have any of these symptoms?
- ☐ Fever > 100.4F or > 38C
- ☐ Fever but do not know exact temperature (no thermometer)
- ☐ New or worsening cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Congestion
- ☐ Shortness of breath
- ☐ Chills/repeated shaking with chills
- ☐ Lack of energy or general tired feeling
- ☐ Loss of appetite, like you just haven't been hungry
- ☐ tightness, or pressure in chest
- ☐ Feeling sick to your stomach or vomiting
- ☐ Diarrhea
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ having hallucinations, altered consciousness
- ☐ Loss of ability to smell
- ☐ Loss of ability to taste
- ☐ No Symptoms

In the two weeks prior to your household member testing positive for COVID-19 did you have any symptoms?
- ◯ Yes
- ◯ No

13 In the two weeks prior to your household member testing positive did YOU have any of these symptoms?

- ☐ Fever > 100.4F or > 38C
- ☐ Fever but do not know exact temperature (no thermometer)
- ☐ New or worsening cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Congestion
- ☐ Shortness of breath
- ☐ Chills/repeated shaking with chills
- ☐ Lack of energy or general tired feeling
- ☐ Loss of appetite, like you just haven't been hungry
- ☐ tightness, or pressure in chest
- ☐ Feeling sick to your stomach or vomiting
- ☐ Diarrhea
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ having hallucinations, altered consciousness
- ☐ Loss of ability to smell
- ☐ Loss of ability to taste
- ☐ No Symptoms

Can you provide a date or day/month of when these symptoms began?
(mm/dd/yy)

_____

Can you provide a date or day/month of when these symptoms began?
(dd/mm/yy)

_____

After your household member testing positive for COVID-19 did you have any symptoms?

- ◯ Yes
- ◯ No

13 After your household member tested positive did YOU have any of these symptoms?

- ☐ Fever > 100.4F or > 38C
- ☐ Fever but do not know exact temperature (no thermometer)
- ☐ New or worsening cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Congestion
- ☐ Shortness of breath
- ☐ Chills/repeated shaking with chills
- ☐ Lack of energy or general tired feeling
- ☐ Loss of appetite, like you just haven't been hungry
- ☐ tightness, or pressure in chest
- ☐ Feeling sick to your stomach or vomiting
- ☐ Diarrhea
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ having hallucinations, altered consciousness
- ☐ Loss of ability to smell
- ☐ Loss of ability to taste
- ☐ No Symptoms

Can you provide a date or day/month of when these symptoms began?
(mm/dd/yy) _____

13 Of all of the symptoms you reported, which one symptom was the most bothersome (i.e., severe) to you?

- ☐ Fever > 100.4F or > 38C
- ☐ Fever but do not know exact temperature (no thermometer)
- ☐ New or worsening cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Congestion
- ☐ Shortness of breath
- ☐ Chills/repeated shaking with chills
- ☐ Lack of energy or general tired feeling
- ☐ Loss of appetite, like you just haven't been hungry
- ☐ tightness, or pressure in chest
- ☐ Feeling sick to your stomach or vomiting
- ☐ Diarrhea
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ having hallucinations, altered consciousness
- ☐ Loss of ability to smell
- ☐ Loss of ability to taste
- ☐ Other

13 Of all of the symptoms you reported, which one symptom was the most bothersome (i.e., severe) to you?

- ☐ Fever > 100.4F or > 38C
- ☐ Fever but do not know exact temperature (no thermometer)
- ☐ New or worsening cough
- ☐ Sore throat
- ☐ Runny nose
- ☐ Congestion
- ☐ Shortness of breath
- ☐ Chills/repeated shaking with chills
- ☐ Lack of energy or general tired feeling
- ☐ Loss of appetite, like you just haven't been hungry
- ☐ tightness, or pressure in chest
- ☐ Feeling sick to your stomach or vomiting
- ☐ Diarrhea
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ having hallucinations, altered consciousness
- ☐ Loss of ability to smell
- ☐ Loss of ability to taste
- ☐ Other

14 How bothersome or distressful was that symptom?

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

14 How bothersome or distressful was that symptom?

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

25 What is your status with respect to your symptoms now?

- ◯ You are recovered and symptom free
- ◯ You are not fully recovered but you can do your usual activities
- ◯ You are recovering but not able to do your daily activities
- ◯ You do not feel like you are recovering
- ◯ Refuse to answer

Which of these symptoms are new or do you still have? (check all that apply)

- ☐ Aches/Pains/Myalgia (back, joint, muscle, etc)
- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Brain Fog/Inability to concentrate
- ☐ Anxiety
- ☐ Stress
- ☐ Cannot walk long distances
- ☐ Cannot walk up stairs
- ☐ Cannot exercise like I did before
- ☐ New Heart Problems (like racing heart, tachycardia, etc)
- ☐ New Kidney Problems (need dialysis or other)
- ☐ New Diabetes
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lower level of energy than usual, increased tiredness beyond normal
- ☐ Other (report in extra box)
- ☐ None

In the two weeks prior to developing symptoms, had you traveled outside of your city/state/country?

- ☐ Yes - outside of Baltimore city
- ☐ Yes - outside of Maryland
- ☐ Yes - outside the country

List the places this person travelled.

_____

22 In the two weeks prior to developing symptoms, did you have contact with a known COVID-19 case?

- ◯ No
- ◯ Yes, someone in my home
- ◯ Yes, someone outside my home
- ◯ Yes, someone inside and outside my home

23 In the two weeks prior to developing symptoms, did you have contact with someone who had symptoms of COVID-19, but who had not yet tested positive or had not yet had a test?

- ◯ No
- ◯ Yes, someone in my home
- ◯ Yes, someone outside my home
- ◯ Yes, someone inside and outside my home

24 Did you consult with a healthcare provider or try to get a coronavirus test because of your symptoms

- ◯ Yes
- ◯ No

25 At what point did you seek care?

- ◯ Immediately when my first symptom began
- ◯ When you developed a fever
- ◯ When you had trouble breathing
- ◯ Some other time

26a How long did it take you to get a test for coronavirus?
- ◯ Same day
- ◯ Within 48 hours
- ◯ More than 48 hours but within a week
- ◯ More than a week

21 How many times have you been tested for coronavirus?

_____

21a When were you first tested for coronavirus?

_____

21b When were you last (most recently) tested for coronavirus?

_____

Have you ever taken a COVID-19 test?
- ◯ Yes
- ◯ No

28 Have you ever tested positive for coronavirus?
- ◯ No, I tested negative
- ◯ Yes, I tested positive
- ◯ My results are pending

21 How many times have you been tested for coronavirus?

_____

29 Have you ever taken medications for the treatment of COVID-19?
- ◯ No
- ◯ Yes
- ◯ Don't know/unsure

29a Were they prescribed to you by a health care provider?
- ◯ No
- ◯ Yes
- ◯ Yes, I took both medications that were and were not prescribed by a health care provider

Which medications have you taken for the treatment of COVID-19?
- ☐ Lopinavir/Ritonavir (Kaletra)
- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Hydroxychloroquine with Azithromycin (Zpack)
- ☐ Chloroquine
- ☐ Ribavirin (Moderiba or Rebetol)
- ☐ Remdesivir
- ☐ Azithromycin (Z pack)
- ☐ Oseltamivir (Tamiflu)
- ☐ Blood from someone who was previously infected (convalescent plasma)
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Zinc
- ☐ Other (specify)

23m1 Please specify

_____

24 Since February 1, 2020, have you been hospitalized for COVID-19 or because you had difficulty breathing or a respiratory infection?
- ◯ Yes
- ◯ No

How long were you hospitalized?

_____

((If you went to the Emergency Room only and didn't get admitted, code 00) [CODE 97 if Don't Know/Unsure])

What was the date of your hospitalization?

_____

26 Why have you not been tested for coronavirus?

- ◯ You haven't felt sick
- ◯ You have felt sick, but didn't feel sick enough to get tested
- ◯ You felt sick but didn't think you had COVID-19
- ◯ You felt sick but weren't aware of COVID-19 until after you felt better
- ◯ You were told by a healthcare provider to self-quarantine instead of getting tested
- ◯ Testing was not available to you
- ◯ You were afraid to get tested
- ◯ You just didn't want to get tested
- ◯ You thought by going to a testing center you would be exposed to/infected with COVID-19
- ◯ You haven't had transportation to or from a testing location
- ◯ You were worried about not being able to pay
- ◯ You didn't know where to go for testing
- ◯ You didn't have someone to watch your children/other people in your care while you went
- ◯ You haven't been able to take time off of work for testing
- ◯ Don't know/Unsure
- ◯ Other (specify)

26a Please specify

_____

We want to know your general state of health before you tested positive or had symptoms of COVID-19. How would you describe your health before you became sick with COVID-19?

- ◯ Excellent (I had no major health issues)
- ◯ Very good (I had no major health issues, but some minor ones)
- ◯ Good (I had one major health issue, but it was controlled)
- ◯ Fair (I had some major and minor health issues)
- ◯ Poor (I had several serious health issues)
- ◯ Refused to answer

	Now I would like to ask you about your other health conditions and pre-existing conditions	☐ Diabetes ☐ Cardiovascular/heart disease ☐ History of heart attack ☐ High blood pressure ☐ High cholesterol ☐ History of stroke ☐ Autoimmune disorder ☐ HIV ☐ Hepatitis C ☐ Asthma/reactive airway disease ☐ Chronic lung disease (COPD, emphysema, etc) ☐ Chronic kidney disease ☐ Cancer diagnosis (within past 12 months) ☐ Depression ☐ Pregnant ☐ Overweight or Obese ☐ Anxiety or other mental health condition
38	Are you limited in any way in any activities because of physical, mental, or emotional problems?	◯ Yes ◯ No
39	Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? (Include occasional use or use in certain circumstances)	◯ Yes ◯ No

How often did you frequent the following places in the two weeks before you or your household member tested positive or had symptoms for COVID-19?

	Daily	Weekly	Monthly	Not since the start of the pandemic	Never
Restaurants (indoor dining)	◯	◯	◯	◯	◯
Restaurants (outdoor dining)	◯	◯	◯	◯	◯
Community Sporting Events (playing or watching)	◯	◯	◯	◯	◯
Walking/Running in neighborhood or park	◯	◯	◯	◯	◯
Grocery Store/Liquor Store	◯	◯	◯	◯	◯
Pharmacy	◯	◯	◯	◯	◯
Gym	◯	◯	◯	◯	◯
Community Pool	◯	◯	◯	◯	◯
Mall	◯	◯	◯	◯	◯
Civil Protest/Political Rally/Large outdoor gathering	◯	◯	◯	◯	◯
School/Work	◯	◯	◯	◯	◯

Are/Were you the primary caregiver for the household member that tested positive for COVID-19?

- ☐ Prepare food and serve household member
- ☐ Bathe household member
- ☐ Clean house
- ☐ Clean around household member

43 Have you or someone in your household had to self-isolate or quarantine? (i.e., you separated themselves from other people, even those in your own household, to prevent others from getting sick)

- ◯ Yes, because you/they had symptoms/were sick
- ◯ Yes, because you/they tested positive for coronavirus
- ◯ Yes, because you/they were exposed to a known case
- ◯ Yes, because you/they were exposed to a suspected case
- ◯ Yes, because you/they were unsure of your infection status
- ◯ No

Did you do any of the following within your household when you had to self-isolate or quarantine from other household members? (Select all that apply)

- ☐ Wear a mask
- ☐ Break isolation for meals
- ☐ Sleep in a different room than others
- ☐ Remain fully in isolation

44 When you or your household member had to self-isolate or quarantine because they were infected, exposed or had symptoms of COVID-19, were they able to maintain the self-isolation/quarantine for the entire time that was recommended?

- ◯ Yes
- ◯ No

44a Why were you/the household member not able to maintain self-isolation/quarantine for the entire time that was recommended?

- ☐ Not enough bedrooms to isolate in own bedroom
- ☐ Had to share a bathroom with others in the household
- ☐ Had to care for young children
- ☐ Had to care for an elderly family member
- ☐ Had to continue working even though I was sick
- ☐ Others in the household were also sick already

42 When did your household start practicing social distancing?

- ☐ Before the March 30th Maryland State Stay at Home Order
- ☐ After the March 30th Maryland State Stay at Home Order
- ☐ When someone in my household got COVID-19 symptom
- ☐ When someone in my household got COVID-19
- ☐ When someone we know (outside of our household) got COVID-19
- ☐ When someone we know died of COVID-19

(@hidden-form @hidden-survey)

41 Has your household practiced social distancing? (i.e., reduced your physical contact with people outside of your home in social, work, or school settings by avoiding large groups and staying 3-6 feet away from other people when out in public)

- ◯ Yes, all household members are practicing social distancing
- ◯ Yes, some but not all household members are practicing social distancing
- ◯ No

Have you been doing any of the following to protect yourself and your family from COVID-19? (Select all that apply)

	Yes	No, I don't see a need to do this	No, I am not able to do this
More handwashing than usual	◯	◯	◯
More use of hand sanitizer than usual	◯	◯	◯
Disinfecting surfaces in your household with bleach/alcohol	◯	◯	◯
Disinfecting or wiping down groceries	◯	◯	◯
Disinfecting or wiping down mail or packages	◯	◯	◯
Reducing how often you go to the store for groceries/supplies	◯	◯	◯
Avoiding or cancelling domestic/international travel	◯	◯	◯
Wearing a mask when out in public	◯	◯	◯
Not having any non-household members in the house	◯	◯	◯

Have you ever been given a vaccine for COVID-19 or enrolled in the COVID-19 clinical vaccine trials?

◯ Yes
◯ No
◯ Don't know
◯ Refused

Which COVID-19 vaccine trial or vaccine were you given?

◯ Moderna mRNA vaccine
◯ Pfizer mRNA vaccine
◯ AstraZeneca attenuated viral vaccine
◯ Johnson & Johnson
◯ NovaVax
◯ Other (specify)
◯ Don't know
◯ Refused

Specify

_____

What was the date of your first vaccination?

_____

What was the date of your second vaccination (if applicable)?

_____
(Leave blank if individual has not yet received the second dose)

If you were enrolled in COVID-19 vaccine trials, do you know if you received the vaccine or a placebo?

◯ Placebo
◯ Vaccine
◯ I was not enrolled in clinical vaccine trials
◯ Don't know
◯ Refused to answer

Any additional comments from the participant (at the discretion of interviewer, meant to catch any points raised but not indicated above).