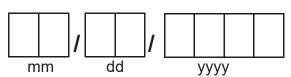
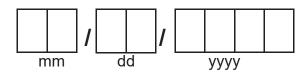
Section A: Demographics

1. What is today's date?



2. What is your date of birth?



- 3. What is your gender?
 - □ Male □ Prefer not to answer
 - ☐ Female

4. Are you Spanish, Hispanic, or Latino?

- □ No, not Spanish, Hispanic, Latino
- Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- Yes, Cuban
- Yes, other Spanish, Hispanic, Latino

5. What is your race? (Mark all that apply)

White

Chinese

- 🛛 Japanese
- Black / African Asian Indian
 - Other Asian
- American Indian 🛛 Filipino
 - / Alaska Native
- ☐ Other

Pacific Islander

- 6. What is your highest degree or level of school you have completed?
 - Less than high school
 - High school diploma / GED
 - □ Some college credit, but no degree
 - Associate's degree (e.g., AA, AS)
 - □ Bachelor's degree (e.g., BA, BS)
 - □ Master's degree (e.g., MA, MS, MBA)
 - □ Professional or Doctorate degree

- 7. What is your current marital status?
 - □ Married □ Divorced
 - □ Civil commitment □ Widowed
 - Cohabitating Never married
 - □ Separated
- 8. Including yourself, how many people currently live in your household?

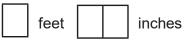
1	2	3	4	5	6	7	8	9+

9. Which income category represents the total income of your household from all sources (before taxes and deductions) during the last 12 months?

□ Less than \$10,000

- □ \$10,000 \$19,999
- □ \$20,000 \$29,999
- □ \$30,000 \$39,999
- □ \$40,000 \$49,999
- □ \$50,000 \$59,999
- □ \$60,000 \$74,999
- □ \$75,000 \$99,999
- □ \$100,000 \$149,999
- □ \$150,000 or more
- Prefer not to answer

10. What is your height:



11. What is your weight:



12. In which branch of the service did you serve? (Mark all that apply)	17. How often do you have six or more drinks on one occasion?				
 Army Navy Merchant Marines Air Force NOAA Coast Guard Public Health Service Marine Corps None (Skip to Qu. 15) 	 Never Less than monthly Monthly 2 – 3 times per week 4 or more times per week 				
 13. Please indicate whether your service was: Active Duty Reserves Only Not Applicable (Not in the military) 	 18. In your lifetime have you smoked a total of at least 100 cigarettes, cigars, or pipes? Yes No (Skip to Qu. 21) 19. Have you ever smoked daily or almost every day for at least one year? Yes No 				
 14. When did you serve? (Mark all that apply) September 2001 or later August 1990 to August 2001 (includes Gulf War) May 1975 to July 1990 August 1964 to April 1975 (Vietnam era) February 1955 to July 1964 July 1950 to January 1955 (Korean War) January 1947 to June 1950 December 1941 to December 1946 (WWII) November 1941 or earlier 	 20. Do you smoke now? Yes, daily Yes, occasionally Not at all The following questions concern electronic vaping products for nicotine use. Do not include marijuana use. 21. Have you ever used an e-cigarette or other electronic vaping product, even just one time, in your entire life? Yes 				
 15. How often do you have a drink containing alcohol? Never (Skip to Qu. 18) 1 – 3 days per month 2 – 3 days per week 6 or more days per week 1 day per week 	 No (Skip to Qu. 23) Prefer not to answer (Skip to Qu. 23) Don't know (Skip to Qu. 23) 22. Do you NOW use e-cigarettes or other electronic vaping products every day, some days, or not at all?				
 16. How many drinks containing alcohol do you have on a typical day when you are drinking? 1 or 2 5 or 6 10 or more 	 Every day Some days Not at all Prefer not to answer Don't know 				

Don't know

□ 3 or 4

🛛 7 to 9

Section B: COVID-19 Exposure/Household Contact

23. Have you been in close contact with anyone with COVID-19 like symptoms?

- Yes, I was in contact with a person with COVID-19 who was confirmed positive by a test
- Yes, I was in contact with a person with COVID-19 symptoms, but was not confirmed by a test

□ No, not to my knowledge

- 24. Has anyone in your household had COVID-19? Please do not include yourself.
 Yes
 Please indicate the number of people.
 No
 People
- 25. Are you a healthcare worker helping to manage patients with COVID-19?

🛛 Don't know

```
🗆 No
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Prefer not to answer

Section C: COVID-19 Symptoms/Diagnosis

26. Have you experienced any of the following symptoms (more than normal) since January 2020? Please check "Yes" or "No" next to each symptom.

If yes, please indicate the number of days you experienced any of these symptoms.	No	Yes	Number of Days You Experienced Symptom
a. Coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours			
b. Shortness of breath			
c. Unusual chest pain or tightness in your chest			
d. Fatigue (struggling to get out of bed)			
e. Feeling of heaviness in arms or legs			
f. Headache			
g. Loss of sense of smell or taste			
h. Sore throat			
i. Diarrhea, nausea and/or vomiting			
j. Fever/chills (temp>100.4 Fahrenheit)			

27. Did you seek advice from a healthcare professional for these symptoms?

	a. If yes,	where did you seek care? (Mark all that apply)
□ Tes □ No (Skip to Qu. 41)		VA facility Doctor's office Emergency department Telemedicine/telephone triage Health department/public health clinic Retail clinic/pharmacy
	b. If yes,	Urgent care Other how long after your symptoms started did you seek care? Less than 2 days
		2 - 7 days Greater than 1 week

28. Did doctors use a laboratory test to check that you didn't have influenza (Flu)?

- Yes
- 🛛 No
- Don't know

29. Have you been diagnosed with COVID-19?

- Yes, confirmed by a positive laboratory test
- Yes, suspected by a doctor but not confirmed by a test (*Skip to Qu. 41*)
- □ No (Skip to Qu. 41)

30. Do you know what type of laboratory test you had for COVID-19?

- ☐ Yes, by nasal swab (PCR)
- ☐ Yes, by blood test (antibody)

☐ Yes, by another test ☐ Don't know

□ Prefer not to answer

Don't know

Friend or other social contact was sick

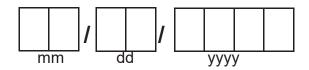
31. Is there a suspected source of your COVID-19?

- Travel related
- □ Family member was sick
- Coworker or other work contact was sick

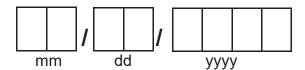
Page 4

Section D: COVID-19 Hospitalization/Treatment

- 32. Were you hospitalized for treatment of COVID-19?
 - □ Yes
 - □ No (Skip to Qu. 38)
- 33. Were you hospitalized at a VA facility?
 - □ Yes
 - 🛛 No
- 34. What date were you admitted to the hospital for treatment of COVID-19?



35. What date were you discharged from the hospital after treatment of COVID-19?



36. Did you require a breathing tube through the mouth for respiratory support while in the hospital (intubation / mechanical ventilation / respirator)?

	Yes
Ц	Yes

- 🛛 No
- 37. Were you hospitalized in an Intensive Care Unit (ICU) for treatment of COVID-19?
 - □ Yes
 - 🗌 No
 - Don't know

- 38. Do you know if doctors used any of the following medications to treat your illness while you were sick with COVID-19? (*Mark all that apply*)
 - □ Tamiflu (oseltamivir) or Xofluza (baloxavir marboxil)
 - □ Chloroquine or Hydroxychloroquine
 - □ Azithromycin
 - Kevzara (sarilumab), Actemra (tocilizumab), Sylvant (siltuximab) or another IL6 pathway blocker medication
 - Baricitinib (Olumiant), Ruxolitinib (Jakafi), tofacitinib (XELJANZ), fedratinib (Inrebic) or another JAK inhibitor medication
 - Remdesivir (GS-5735)
 - Darunavir (Prezista), Lopinavir/Ritonavir (Kaletra) or another protease inhibitor
 - □ Favipiravir (Avigan)
 - □ Sofosbuvir or ribavirin
 - □ None of the above
 - Don't know
- 39. Did you receive respiratory support at home to treat your COVID-19, such as oxygen therapy by nasal prong or facemask or CPAP machine?



40. If yes, for how long did you need respiratory support at home? *Please enter the duration of your respiratory support in days.*



Section E: COVID-19 Impact Behavior/Well-Being

The next questions ask about your behaviors and well-being since the COVID-19 pandemic and the impact it has had on you.

41. Which of the following have you done since the COVID-19 pandemic? (Mark all that apply)

Used a face mask or other face covering	Practiced social distancing (avoiding contact
while in public	with anyone outside of the home)
\Box Used gloves while in public	\square Avoided contact with people who could be
\square Washed your hands with soap or used	high-risk
hand sanitizer several times a day	Avoided eating at restaurants
Cleaned high touch surfaces like door	\square Avoided public spaces, gatherings, or
handles, counters, faucets, and remote	crowds
controls	\square Avoided gatherings of more than 50 people
	Cancelled doctor's appointments

42. Since the COVID-19 pandemic started, have any of the following aspects of your life changed?

		Decreased	Stayed the Same	Increased	Not Applicable
a.	Amount you sleep				
b.	Amount of physical activity you do				
C.	Amount you smoke/vape				
d.	Amount of alcohol you drink				
e.	Number of hours you work in usual workplace				
f.	Number of hours you work at home				
g.	Time spent talking to family/friends				
h.	Time spent talking to work colleagues				
i.	Practicing relaxation / mindfulness / meditation				
j.	Time watching TV/streaming services				
k.	Time spent reading or listening to the news				
I.	Time spent on social media				
m.	Time spent playing video games				
n.	Time spent doing hobbies/things you enjoy				
о.	Amount you eat				
p.	Amount of money you've spent				

43. Over the past 2 weeks, have you been bothered by any of these problems?

		Not at all	Several days	More days than not	Nearly every day
a.	Feeling nervous, anxious, or on edge				
b.	Not being able to stop or control worrying				
c.	Feeling down, depressed, or hopeless				
d.	Little interest or pleasure in doing things				

44. Since the COVID-19 pandemic, for each of the statements below please select the best choice that describes how you feel. Select only one response for each question or statement.

		Never	Rarely	Sometimes	Usually	Always	Don't know or N/A
Social Isolation							
a.	I feel left out						
b.	I feel that people barely know me…						
с.	I feel isolated from others						
d.	I feel that people are around me, but not with me						

45. Since the COVID-19 pandemic, for each of the statements below please select the best choice that describes how you feel. Select only one response for each question or statement.

Emo	tional Support	Never	Rarely	Sometimes	Usually	Always	Don't know or N/A
а.	I have someone who will listen to me when I need to talk.						
b.	I have someone to confide in or talk to about myself or my problems.						
C.	I have someone who makes me feel appreciated.						
d.	I have someone to talk with when I have a bad day.						

46. Since the COVID-19 pandemic, for each of the items below please select the best choice describing the degree of impact. Select only one response for each question or statement.

		No Loss	Minimal Loss	Noticeable Loss	Extreme Loss	Don't Know or N/A
a.	Adequate food					
b.	Your residence / home you live in					
c.	Things you need for your children or members of your household					
d.	Money for extras					
e.	Savings or emergency money					
f.	Adequate income					
g.	Financial credit					
h.	Your retirement security					
i.	Free time					
j.	Time for enough sleep					
k.	Feeling valuable to other people					
I.	A feeling of intimacy with one or more family members					
m.	The feeling that you're accomplishing the goals in your life					
n.	Time with your loved ones					
о.	The sense of a daily routine					
p.	Health of a family member / friend					
q.	Stable employment					
r.	Ability to organize tasks					
s.	Time needed to do your work					
t.	Understanding from your boss					
u.	Support from your co-workers					
v.	The chance to get more training or education					

	Continued	No Loss	Minimal Loss	Noticeable Loss	Extreme Loss	Don't Know or N/A
w.	Feeling of being independent					
х.	Companionship with others					
у.	Feeling that your life has meaning or purpose					
z.	Involvement with your church					
aa.	Help with tasks at home					
bb.	Loyalty of friends					
cc.	Help with childcare					
dd.	Involvement in organizations or clubs					

Section F: Medical Conditions/Comorbidity

47. We'd like to ask about your general health. Please tell us if you have ever been diagnosed with the following conditions. Check the appropriate box and indicate the year of diagnosis and whether you currently take any medication(s) ("TAKE MEDS") for that condition. (*Mark all that apply*)

Circulatory System Problems			Mental Health Disorders			
	YES DI	YEAR AGNOSED	TAKE MEDS		YES	YEAR TAKE DIAGNOSED MEDS
High blood pressure (Hypertension)				Anxiety reaction / Panic disorder		
Stroke				Attention deficit hyper- activity disorder (ADHD)		
Transient ischemic attack (TIA)				Bipolar disorder		
Heart attack				Post traumatic stress disorder (PTSD)		
Coronary artery / Coronary heart disease (includes angina)				Depression		
Peripheral vascular disease				Eating disorder		
High cholesterol				Personality disorder		
Pulmonary embolism or deep vein thrombosis (DVT)				Schizophrenia		
Congestive heart failure				Social phobia		
Other circulatory system problem				Other mental health disorder		
Skeletal / Muscular Problems			Hearing / Vision			
	YES DI	YEAR AGNOSED	TAKE MEDS		YES	YEAR TAKE DIAGNOSED MEDS
Osteoarthritis				Cataracts		
Rheumatoid arthritis				Glaucoma		
Other arthritis				Macular degeneration		
Gout				Blindness, all causes		
Osteoporosis				Tinnitus or ringing in the ears		
Other skeletal / muscular problem				Severe hearing loss or partial deafness in one or both ears		

Infectious	s Dise	eases		Ca	ancer		
	YES	YEAR DIAGNOSED	TAKE MEDS		YES	YEAR DIAGNOSED	TAKE MEDS
Tuberculosis				Breast cancer] 🗆
Hepatitis C] 🗆	Colon cancer / Rectal cancer] 🗆
HIV / AIDS] 🗆	Lung cancer] 🗆
Other infectious disease] 🗆	Prostate cancer] 🗆
Kidney	Disea	ase		Skin cancer] 🗆
	YES	YEAR DIAGNOSED	TAKE MEDS	Other cancer] 🗆
Kidney disease without dialysis] 🗆	Nervous S	ystem	Problems	
Kidney disease with dialysis] 🗆		YES	YEAR DIAGNOSED	TAKE MEDS
Acute kidney disease with no current dialysis	η Π] 🗆	Migraine headaches] 🗆
Digestive Sy	stem	Problems		Other headaches] 🗆
	YES	YEAR DIAGNOSED	TAKE MEDS	Memory loss or impairment] 🗆
Acid reflux / GERD] 🗆	Dementia (includes Alzheimer's, vascular, etc.)] 🗆
Peptic ulcers				Concussion or loss of consciousness] 🗆
Bowel obstruction] 🗆	Traumatic brain injury] 🗆
Colon polyps] 🗆	Spinal cord injury or impairment] 🗆
Irritable bowel syndrome (IBS)				Epilepsy / Seizure] 🗆
Ulcerative colitis] 🗆	Parkinson's disease] 🗆
Crohn's disease] 🗆	Amyotrophic lateral sclerosis (Lou Gehrig's disease)] 🗆
Celiac disease / Sprue] 🗆	Multiple sclerosis] 🗆
Other digestive system disorder] 🗆	Other nervous system problem			

Other Conditions

	YES	YEAR DIAGNOSED	TAKE MEDS
Asthma			
Chronic lung disease (COPD, Emphysema or Bronchitis)			
Diabetes / "sugar"			
Enlarged prostate (Benign prostatic hyperplasia)			
Liver condition (e.g., Cirrhosis)			
Skin condition (e.g., Eczema, Psoriasis)			
Sleep apnea			
Thyroid problems			
Gulf War Illness/ Syndrome			
Chronic Fatigue Syndrome	•		
Fibromyalgia			
Other disease / disorder			

48. Did you receive the following vaccines while in the military? *If yes, please write in the year of the last vaccine dose.*

the year of the last vaccine dose.	□ Excellent □ Fair
Anthrax	□ Very Good □ Poor
Year Vaccinated: No Don't Know	 Good 50. In the PAST YEAR, have you received health care that was paid for by any of the following incomes to paid for by any of the following incomes to paid for by any of the following incomes to paid for by any of the following paid following p
_	following insurance types? (Mark all that apply)
Small Pox Yes Year Vaccinated: No Don't Know	 Private insurance TRICARE Medicare Medicaid Veterans Choice Program VA health care Indian Health
Rabies Yes Year Vaccinated: No Don't Know	51. In the PAST YEAR, about how much of your health care did you get at a VA facility (e.g., doctor's visits, hospitalizations, urgent care visits, or counseling)?
Yellow Fever	□ None □ 51 – 75%
Year Vaccinated: No	\Box 1 - 25% \Box 76 - 99% \Box 26 - 50% \Box 100%
Don't Know	52. In the PAST YEAR, how many times were you a patient in a hospital overnight or
Typhoid Yes Year Vaccinated: No Don't Know	Ionger? VA Facility □ None □ 4 - 6 □ 10 or more □ 1 - 3 □ 7 - 9 Non-VA Healthcare Facility
Japanese Encephalitis	\Box None \Box 4 - 6 \Box 10 or more
Year Vaccinated: No Don't Know	□ 1 - 3 □ 7 - 9

49. In general, would you say your health is:

53. How many <u>prescription</u> medications do you currently receive from:

VA Pharmacy

- □ None
- 4 6 □ 10 or more 07-9
- 1 3

Non-VA Pharmacy

- □ None
- 4 6 1 - 3 07-9
- 10 or more

54. How many <u>non-prescription</u> medications do you currently receive from:

VA Pharmacy

□ None □ 1 - 3	□ 4 - 6 □ 7 - 9	□ 10 or more
Non-VA Phar	тасу	
□ None □ 1 - 3	□ 4 - 6 □ 7 - 9	□ 10 or more