Participant ID:	**Participant Initials:**
Site:	**Visit Number:**
CRF Date:	**RC ID:**

COVID-19 QUESTIONNAIRE

Display Name- 24 hours: COVID-19 Questionnaire

The following questions ask about your COVID-19 related experiences

1. Have you had COVID-19, or the illness caused by the novel coronavirus?

   ☐ No
   ☐ Yes, definitely
   ☐ Yes, I think so
   ☐ Maybe

2. Has a healthcare provider ever told you that you had COVID-19?

   ☐ No (Skip to Q3)
   ☐ Yes, definitely
   ☐ Yes, probably or suspected

   2a. Have you recovered to your usual state of health from your COVID-19 illness?
   ☐ No (Skip to Q2c)
   ☐ Yes

   2b. How long did it take for you to recover? (Days) _____

   2c. What was the approximate date of this illness? ___/___/___ (MM/DD/YY)

   2d. Approximately how many days did the symptoms last? (Days) _____ days

3. Have you been tested for coronavirus or COVID-19?

   ☐ No (Skip to Q4)
   ☐ Yes
   ☐ Unsure (Skip to Q4)

   3a. How many times have you been tested? _____ Times

   The following questions will ask for details regarding your first COVID-19 test

   3b. What was the date of your first COVID-19 test? ___/___/___ (MM/DD/YY)

   3c. Reasons for first COVID-19 test:

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3c1. I had symptoms of COVID-19 ☐ Yes ☐ No

Reasons for first COVID-19 test:
3c2. Someone I know had symptoms of COVID-19 ☐ Yes ☐ No

Reasons for first COVID-19 test:
3c3. A doctor told me to be tested for COVID-19 ☐ Yes ☐ No

Reasons for first COVID-19 test:
3c4. I was worried about COVID-19 ☐ Yes ☐ No

Any additional reasons for your first COVID-19 test?
☐ Yes ☐ No

Please describe reason: _____

3d. Type of test for first COVID-19 test:

☐ Nasopharyngeal swab
☐ Blood test
☐ Saliva test
☐ Other

2d. If other, please specify:_____

3e. What was the result of your first COVD-19 test?

☐ Positive for COVID-19 virus (Skip to Q4)
☐ Negative for COVID-19 virus
☐ Unsure

3f. Did you ever test positive for the COVID-19 virus?
☐ No
☐ Yes

4. Have you ever had an overnight stay in a hospital for suspected or diagnosed COVID-19?

☐ No (Skip to Q5)
☐ Yes

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4a. How many nights were you in the hospital? _____ nights

4a1. Date arrived at hospital: ___/___/___ (MM/DD/YY)

4a2. Date discharged from hospital: ___/___/___ (MM/DD/YY)

4b. For ascertainment of medical records please list the hospital name, city, and state:

_____

5. How many people live in your household (or the place you are residing)?

- ☐ Live alone (Skip to Q6)
- ☐ Two people
- ☐ Three people
- ☐ More than three people

5a. How many people in your household (or the place you are residing) **other than yourself** have been tested for COVID-19?

- ☐ None (Skip to Q6)
- ☐ One person
- ☐ Two people
- ☐ Three people
- ☐ More than three people

5b. How many of the test results are positive for the COVID-19 virus?

- ☐ None (Skip to Q6)
- ☐ One
- ☐ Two
- ☐ Three
- ☐ More than three

5c. Did you change your behavior at home?

- ☐ No (Skip to Q6)
- ☐ Yes

5c1. Did you wear a mask at home?

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☐ No
☐ Yes

5c2. Did the infected person(s) wear a mask at home?

☐ No
☐ Yes

6. May we also call you in the future to see how you are doing and ask you these questions again?

☐ No
☐ Yes

Thank You for Completing this Questionnaire!