

BASELINE COVID-19 QUESTIONNAIRE

Visit 1

Participant ID#: _____ P _____
Date: ____ / ____ / ____

Please answer each of the questions to the best of your ability. There are no right or wrong answers.

1. Since January 2020, have you had an illness that you thought might be COVID-19?

☐ Yes → When did you have an illness you thought might be COVID-19?
____ / ____ (mm/yyyy)

☐ No

2. Have you been told by a doctor or other healthcare professional that you had COVID-19?

☐ Yes → When were you told by a doctor or other healthcare professional that you had COVID-19? ____ / ____ (mm/yyyy)

☐ No

3. Have you ever been tested for COVID-19?

☐ Yes → Please complete Question 3a ☐ No → Skip to Question 4

3a. Have you ever had a test that was positive for COVID-19?

☐ Yes → Please complete table below ☐ No → Skip to Question 3b

Please complete the table below with information for any positive COVID-19 tests you've had.

Date of Test (dd/mm/yyyy)		Type of Test (check one)		
1	____ / ____ / ____	☐ Nasal swab ☐ Blood	☐ Mouth swab ☐ Other, specify: _____	☐ Saliva/Spit test
2	____ / ____ / ____	☐ Nasal swab ☐ Blood	☐ Mouth swab ☐ Other, specify: _____	☐ Saliva/Spit test
3	____ / ____ / ____	☐ Nasal swab ☐ Blood	☐ Mouth swab ☐ Other, specify: _____	☐ Saliva/Spit test
4	____ / ____ / ____	☐ Nasal swab ☐ Blood	☐ Mouth swab ☐ Other, specify: _____	☐ Saliva/Spit test
5	____ / ____ / ____	☐ Nasal swab ☐ Blood	☐ Mouth swab ☐ Other, specify: _____	☐ Saliva/Spit test



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3b. Have you ever taken a test that was negative for COVID-19?

☐ Yes → Please complete table below ☐ No → Skip to Question 3c

Please complete the table below with information for any negative COVID-19 tests you've had.

Date of Test (dd/mm/yyyy)	Type of Test (check one)
1 ____ / ____ / ____	☐ Nasal swab ☐ Mouth swab ☐ Saliva/Spit test ☐ Blood ☐ Other, specify: _____
2 ____ / ____ / ____	☐ Nasal swab ☐ Mouth swab ☐ Saliva/Spit test ☐ Blood ☐ Other, specify: _____
3 ____ / ____ / ____	☐ Nasal swab ☐ Mouth swab ☐ Saliva/Spit test ☐ Blood ☐ Other, specify: _____
4 ____ / ____ / ____	☐ Nasal swab ☐ Mouth swab ☐ Saliva/Spit test ☐ Blood ☐ Other, specify: _____
5 ____ / ____ / ____	☐ Nasal swab ☐ Mouth swab ☐ Saliva/Spit test ☐ Blood ☐ Other, specify: _____

3c. If you were tested for COVID-19, were you tested because: (check all that apply)

- ☐ You had symptoms
☐ You had contact with person(s) with COVID-19
☐ Screening for your job in your community
☐ Other, Specify: _____

4. If you have had COVID-19 or thought you had COVID-19, did you have any of the following symptoms related to your illness? If you have not had, or don't think you've had COVID-19, please skip to Question 9.

☐ Yes → (Check all that apply)

- | | |
|---|---|
| ☐ Fever or chills | ☐ Sore throat |
| ☐ Increased or new shortness of breath | ☐ Congestion or runny nose |
| ☐ Increased or new cough | ☐ Headache |
| ☐ Chest pain | ☐ Loss of smell or taste |
| ☐ Abdominal pain | ☐ Confusion |
| ☐ Nausea or vomiting | ☐ Trouble sleeping |
| ☐ Diarrhea | ☐ Conjunctivitis |
| ☐ Muscle aches or joint pain | ☐ Skin changes |
| ☐ Increased or new fatigue | ☐ Other, Specify: _____ |

☐ No



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5. Are you recovered from your COVID-19 illness now?

- ☐ Yes, completely → How long did it take to return to your usual state of health? # of _____ days **OR**
of _____ weeks **OR**
of _____ months
- ☐ No, better but still have some problems
- ☐ No, still have major problems or are disabled from COVID-19

5a. If you answered NO to Question 5, are you still having any of the below symptoms/problems related to your COVID-19? (check all that apply)

- ☐ Yes → **(Check all that apply)**
- | | |
|---|---|
| ☐ Fever or chills | ☐ Sore throat |
| ☐ Increased or new shortness of breath | ☐ Congestion or runny nose |
| ☐ Increased or new cough | ☐ Headache |
| ☐ Chest pain | ☐ Loss of smell or taste |
| ☐ Abdominal pain | ☐ Confusion |
| ☐ Nausea or vomiting | ☐ Trouble sleeping |
| ☐ Diarrhea | ☐ Conjunctivitis |
| ☐ Muscle aches or joint pain | ☐ Skin changes |
| ☐ Increased or new fatigue | ☐ Other, Specify: _____ |
- ☐ No

5b. Are you experiencing any of the following new problems since your acute COVID-19 illness? (check all that apply)

- | | |
|--|---|
| ☐ Problems with your memory | ☐ Inability to exercise at pre-COVID level |
| ☐ Problems with paying attention | ☐ Inability to return to work (if you were working pre-COVID) |
| ☐ Problems with your appetite | ☐ Inability to return to your usual pre-COVID activities |
| ☐ Problems with feeling lightheaded | ☐ Feeling weak, tired, and/or sick 24-48 hours after physical activity |
| ☐ Trouble sleeping | ☐ Other, Specify: _____ |
| ☐ Periods of racing heart | |

6. Have you had an overnight stay in a hospital due to any illness related to COVID-19?

- ☐ Yes → How many nights did you stay in the hospital? _____ nights
- ☐ No → **Skip to Question 7**

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6a. While in the hospital, did you have any of the following?

- | | |
|--|--|
| Oxygen (by mask or nose) | ☐ Yes ☐ No |
| A breathing tube or ventilator to help you breathe | ☐ Yes ☐ No |
| Intensive care unit (ICU) or ICU monitoring | ☐ Yes ☐ No |
| Dialysis | ☐ Yes ☐ No |

7. Were you prescribed medication(s) for COVID-19?

- ☐ Yes → Which medication(s)? _____
- ☐ No
- ☐ Don't know

8. Has a healthcare provider ever told you that you may have gotten COVID-19 a second time, or that you have been "re-infected" with COVID-19?

- ☐ Yes → Continue on to Questions 8a – 8d
- ☐ No → Skip to Question 9

8a. Not counting your original infection, how many more times do you think you have been re-infected with COVID-19?

- ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

8b. When do you know or think you were first re-infected with COVID-19?

____ / ____ (mm/yyyy) *please estimate even if you are not sure

8c. At that time, what made you think you had been re-infected? (check all that apply)

- ☐ You had another test that showed you had COVID-19
- ☐ You had symptoms of COVID-19 (fever, cough, trouble breathing)
- ☐ You had contact with person(s) with COVID-19
- ☐ Other, Specify: _____

8d. This time, when you were re-infected, how did your symptoms compare to your first infection with COVID-19?

- ☐ Worse than the first infection
- ☐ About the same as the first infection
- ☐ Better than the first infection
- ☐ You had no symptoms

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9. Have you received a vaccine for COVID-19?

☐ Yes → When did you receive your first vaccine? ____ / ____ (mm/yyyy)

☐ No → Skip to Question 10

9a. Did you receive a second vaccine for COVID-19?

☐ Yes → When did you receive your second vaccine? ____ / ____ (mm/yyyy)

☐ No

9b. Are you (or were you) part of a COVID-19 vaccine research study?

☐ Yes

☐ No

9c. Which vaccine did you receive?

☐ Moderna

☐ Pfizer

☐ AstraZeneca

☐ Johnson & Johnson

☐ Unknown

☐ Other, Specify: _____

10. This is a list of potential actions we want to know if you have taken, over the past 4 months, to reduce your risk of exposure to COVID-19. You can say “most or all of the time,” “sometimes,” or “rarely or never.”

- | | | | |
|--|---|------------------------------------|---------------------------------------|
| a. Staying at home | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| b. Avoiding contact with people outside of my home | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| c. Washing hands or using sanitizer frequently | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| d. Staying at least 6 feet away from others | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| e. Avoiding large gatherings | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| f. Avoiding eating indoors at restaurants/bars | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| g. Cancelled planned travel | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| h. Wearing a face mask | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| i. Not shaking hands or touching people | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| j. Not going to work (working remotely) | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |
| k. Wiping down surfaces with disinfectant | ☐ Most/all times | ☐ Sometimes | ☐ Rarely/Never |