PRECISIONS
Prospective tReatment EffiCacy in IPF uSIng genOtype for Nac Selection (PRECISIONS) trial

COVID-19 QUESTIONNAIRE Follow-up

Visit #: _____

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

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

1. <u>Since your last study visit</u>, 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. <u>Since your last study visit</u>, 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. <u>Since your last study visit</u>, have you been tested for COVID-19?

☐ Yes ➔ **Please complete Question 3a** ☐ No ➔ **Skip to Question 4**

3a. <u>Since your last study visit</u>, have you had a test that was <u>positive</u> for COVID-19?

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

Please complete the table below with information for any <u>positive</u> COVID-19 tests you've had <u>since your last study visit</u>.

	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: _____

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3b. Since your last study visit, have you 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 since your last study visit.

	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 since your last study visit, 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 _____

4. If you have had COVID-19, or thought you had COVID-19 since your last study visit, did you have any of the following symptoms? 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
☐ Increased or new shortness of breath
☐ Increased or new cough
☐ Chest pain
☐ Abdominal pain
☐ Nausea or vomiting
☐ Diarrhea
☐ Muscle aches or joint pain
☐ Increased or new fatigue
☐ Sore throat
☐ Congestion or runny nose
☐ Headache
☐ Loss of smell or taste
☐ Confusion
☐ Trouble sleeping
☐ Conjunctivitis
☐ Skin changes
☐ 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. <u>If you answered NO to Question 5</u>, are you still have any of the below symptoms/problems related to your COVID-19? (check all that apply)

☐ Yes ➔ **(Check all that apply)**

- ☐ Fever or chills
- ☐ Increased or new shortness of breath
- ☐ Increased or new cough
- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Muscle aches or joint pain
- ☐ Increased or new fatigue
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Headache
- ☐ Loss of smell or taste
- ☐ Confusion
- ☐ Trouble sleeping
- ☐ Conjunctivitis
- ☐ Skin changes
- ☐ 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
- ☐ Problems with paying attention
- ☐ Problems with your appetite
- ☐ Problems with feeling lightheaded
- ☐ Trouble sleeping
- ☐ Periods of racing heart
- ☐ Inability to exercise at pre-COVID level
- ☐ Inability to return to work (if you were working pre-COVID)
- ☐ Inability to return to your usual pre-COVID activities
- ☐ Feeling weak, tired, and/or sick 24-48 hours after physical activity
- ☐ Other, Specify:_____

6. <u>Since your last study visit</u>, have you had an overnight stay in a hospital due to 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. <u>Since your last study visit</u>, were you prescribed medication(s) for COVID-19?

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

8. Has a healthcare provider told you that you may have had more than one COVID-19 infection, 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 <u>re-infected</u> 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. <u>Since your last study visit</u>, 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, <u>since your last study visit</u>, 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	☐ Most/all times	☐ Sometimes	☐ Rarely/Never
k.	Wiping down surfaces with disinfectant	☐ Most/all times	☐ Sometimes	☐ Rarely/Never

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