Form Approved

OMB No. 0920-XXXX

Exp. Date: xx/xx/2020

Please affix label here

COVID-19 Community Seroepidemiological Investigation

# Individual Questionnaire

Team #\_\_\_\_\_\_ Cluster ID # \_\_\_\_\_\_ Household ID #\_\_\_\_\_\_ Individual CSID # \_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

**Please complete the following questions for each person in the household**

## Information about recent illness

1. Since January 1, 2020, have you been sick for more than one day?

[ ] Yes [ ] No [ ] Don’t know or can’t remember

**(If none or don’t know/can’t remember, skip to question ‎‎2.)**

1. Were you sick more than one time between January and now?

[ ] Yes [ ] No [ ] Don’t know or can’t remember

1. If **YES**, how many times were you ill? \_\_\_ times

(If **YES,** please complete questions 3 – 16 for the first illness episode and complete **Sub-appendix 1** for each

subsequent illness episode.)

1. Are you **currently** having fever, cough, or difficulty breathing?

[ ] Yes [ ] No [ ] Don’t know

**(Skip to section, “Specific illness episode‎”‎.)**

1. If **NO or DON’T KNOW OR CAN’T REMEMBER** to question 1, have you ever been tested for SARS-CoV-2 (also called COVID-19)?

[ ] Yes [ ] No [ ] Don’t know

**(If no or don’t know, skip to question ‎‎14.)**

1. If **YES**, on approximately which date were you tested? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Don’t know or can’t remember

CDC estimates the average public reporting burden for this collection of information as 20 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

1. What was your test result?

[ ] Positive [ ] Negative [ ] Have not received test result [ ] Don’t know

**(Skip to question ‎‎14.)**

## Specific illness episode

**Please complete this section, “Specific illness episode,” for the first illness episode. If there are subsequent illness episodes, please complete Sub-appendix 1 for each.**

1. When was the first day that you began to feel sick (use calendar)? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Precise date cannot be recalled

If the precise date cannot be recalled, please give month \_\_\_\_\_\_\_ and year \_\_\_\_\_\_\_\_

1. When was the first day that you began to feel well again (use calendar)? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Precise date cannot be recalled

If the precise date cannot be recalled, please give month \_\_\_\_\_\_\_ and year \_\_\_\_\_\_\_\_

1. During the time that you were sick, which of the following symptoms did you have?

* Fever measured by thermometer [ ] Yes [ ] No [ ] Don’t know

If **YES**, maximum recorded temperature: \_\_\_\_\_\_\_ F / C

* Felt feverish [ ] Yes [ ] No [ ] Don’t know
* Chills [ ] Yes [ ] No [ ] Don’t know
* Cough [ ] Yes [ ] No [ ] Don’t know
* Sore throat [ ] Yes [ ] No [ ] Don’t know
* Runny or stuffy nose [ ] Yes [ ] No [ ] Don’t know
* Difficulty breathing [ ] Yes [ ] No [ ] Don’t know
* Muscle pain [ ] Yes [ ] No [ ] Don’t know
* Chest pain [ ] Yes [ ] No [ ] Don’t know
* Abdominal pain [ ] Yes [ ] No [ ] Don’t know
* Nausea/vomiting [ ] Yes [ ] No [ ] Don’t know
* Diarrhea [ ] Yes [ ] No [ ] Don’t know
* Headache [ ] Yes [ ] No [ ] Don’t know
* Fatigue [ ] Yes [ ] No [ ] Don’t know
* Loss of sense of smell or taste [ ] Yes [ ] No [ ] Don’t know
* Other (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Yes [ ] No [ ] Don’t know

1. Did you go to a doctor, clinic, or emergency room because of this illness?

[ ] Yes [ ] No (skip to 9) [ ] Don’t know or can’t remember

1. Did you stay overnight in the hospital for this illness?

[ ] Yes [ ] No [ ] Don’t know or can’t remember

1. If **YES**, on which date were you admitted to the hospital? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)
2. For how many days were you hospitalized? \_\_\_\_\_\_\_\_ days
3. If **YES** to question ‎6, did you receive a diagnosis for this illness??

[ ] Yes [ ] No [ ] Don’t know or can’t remember

1. If **YES**, please specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Were you tested for influenza/flu?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, on approximately which date were you tested? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Don’t know or can’t remember

1. If **YES,** what was your test result?

[ ] Positive [ ] Negative [ ] Have not received test result [ ] Don’t know

1. Were you tested for SARS-CoV-2 (also called COVID-19)?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, on approximately which date were you tested? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Don’t know or can’t remember

1. If **YES**, what was your test result?

[ ] Positive [ ] Negative [ ] Have not received test result [ ] Don’t know

1. Did you miss any days of school or work because of this illness?

[ ] Yes [ ] No [ ] Don’t know/remember

A. If **YES**, how many days of school or work did you miss? \_\_\_\_\_\_\_\_ days

1. While you were sick, how often did you go to public places (e.g., school, work, store, place of worship) during the 7 days after your illness began except for visiting the doctor?

[ ] Multiple times per day [ ] Once per day [ ] Several times during the 7-day period

[ ] Rarely [ ] Never [ ] Don’t know

1. While you were sick, did any family or friends come over to visit you?

[ ] Yes [ ] No [ ] Don’t know

## Medical history

1. Do you have any of the following medical conditions?

* Seasonal allergies [ ] Yes [ ] No [ ] Don’t know
* Chronic Lung Disease [ ] Yes [ ] No [ ] Don’t know
  + Asthma/reactive airway disease [ ] Yes [ ] No [ ] Don’t know
  + Emphysema/COPD [ ] Yes [ ] No [ ] Don’t know
  + Other (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Yes [ ] No [ ] Don’t know
* Diabetes Mellitus [ ] Yes [ ] No [ ] Don’t know
* Cardiovascular disease [ ] Yes [ ] No [ ] Don’t know
  + Hypertension [ ] Yes [ ] No [ ] Don’t know
  + Coronary artery disease [ ] Yes [ ] No [ ] Don’t know
  + Heart failure/Congestive heart failure [ ] Yes [ ] No [ ] Don’t know
  + Cerebrovascular accident/Stroke [ ] Yes [ ] No [ ] Don’t know
  + Congenital heart disease [ ] Yes [ ] No [ ] Don’t know
  + Other (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Yes [ ] No [ ] Don’t know
* Kidney disease [ ] Yes [ ] No [ ] Don’t know
  + Dialysis [ ] Yes [ ] No [ ] Don’t know
* Liver disease [ ] Yes [ ] No [ ] Don’t know
* Immunocompromised Condition [ ] Yes [ ] No [ ] Don’t know
  + HIV infection [ ] Yes [ ] No [ ] Don’t know
  + AIDS or CD4 count <200 [ ] Yes [ ] No [ ] Don’t know
  + Solid organ transplant [ ] Yes [ ] No [ ] Don’t know
  + Stem cell transplant [ ] Yes [ ] No [ ] Don’t know
  + Cancer [ ] Yes [ ] No [ ] Don’t know

current/in treatment or diagnosed in last 12 months

* + Other (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Yes [ ] No [ ] Don’t know
* Immunosuppressive therapy

(specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Yes [ ] No [ ] Don’t know

* Neurologic/neurodevelopmental disorder [ ] Yes [ ] No [ ] Don’t know

(specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Other chronic diseases [ ] Yes [ ] No [ ] Don’t know

(specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. Are you currently pregnant or have you had a child within the last 6 weeks?

[ ] Yes [ ] No [ ] Don’t know [ ] Not applicable

1. Are you currently breastfeeding?

[ ] Yes [ ] No [ ] Don’t know [ ] Not applicable

1. If the household member is a young child, is he/she/they currently being breastfed?

[ ] Yes [ ] No [ ] Don’t know [ ] Not applicable

## Employment

1. Do/did you attend or work in a school or daycare?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, last date that you were in the school or daycare: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ [ ] Still working in/going to daycare
2. Do you work in a hospital, doctor’s office, or other healthcare setting? Please select all that apply.

[ ] Does not work in a healthcare setting (skip to 20) [ ] Urgent care facility [ ] Outpatient clinic

[ ] Emergency department [ ] Hospital [ ] Long-term care facility

[ ] Assisted living facility [ ] Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your occupation?

[ ] Nurse [ ] Nurse aid [ ] Physician [ ] Respiratory therapist [ ] Housekeeping/janitorial

[ ] Administrative/clerical [ ] Physical/occupational therapist

[ ] Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the respondent is a healthcare worker as listed above, skip to the section, “Exposures.”**

1. Do you work at a place that is considered an “essential service”?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, what type of essential service field do you work in:

[ ] Grocery store [ ] Restaurant [ ] Non-grocery store

[ ] Home health-aid/care-giver [ ] Pharmacy

[ ] Warehouse/shipping center [ ] Government/public service

[ ] Delivery driver, parcel (e.g., USPS, UPS, Fedex) [ ] Delivery driver, food (e.g., grocery, restaurant, Uber Eats)

[ ] Public transportation/airline/airport [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please describe your employment status now or at the start of the COVID-19 outbreak.

[ ] Employed, currently working outside of the house (some days or everyday)

[ ] Employed, teleworking every day that I work

[ ] Employed, furloughed or lost job since outbreak started

[ ] Not employed

[ ] Retired

1. What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If **TELEWORKING or FURLOUGHED/LOST JOB**, what is the last date that you worked outside of your home? \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

## Exposures

1. Have you had contact with anyone with diagnosed (laboratory confirmed) SARS-CoV-2 infection (also called COVID-19) while they were sick or in the 3 days before they became sick?

[ ] Yes, 1 person [ ] Yes, more than 1 person [ ] No [ ] Don’t know

1. If **YES**, what was the last date of contact? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ [ ] Don’t know

1. Relationship to person(s) with confirmed SARS-CoV-2 infection (check all that apply)

[ ] Spouse/Partner [ ] Child [ ] Parent [ ] Other Family [ ] Friend

[ ] HCW [ ] Co-worker [ ] Classmate [ ] Roommate [ ] Patient

[ ] Client [ ] Contact only – no relationship [ ] Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you take care of this/these person(s)?

[ ] Yes [ ] No [ ] Don’t know

1. Have you had contact with anyone who did not have a laboratory-confirmed SARS-CoV-2 infection but had respiratory symptoms while they were sick or in the 3 days before they became sick?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, when was the last date of contact? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ [ ] Don’t know

1. Relationship to sick person(s) (check all that apply)

[ ] Spouse/Partner [ ] Child [ ] Parent [ ] Other Family [ ] Friend

[ ] HCW [ ] Co-worker [ ] Classmate [ ] Roommate

[ ] Contact only – no relationship [ ] Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you traveled out of the state or country since January 2020?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, how many trips? \_\_\_\_\_\_\_\_\_ trips

## Travel

1. Traveled to:

| **Traveled to** (specify state/country) | **Arrived** (mm/dd/yyyy) | **Departed** (mm/dd/yyyy) |
| --- | --- | --- |
| Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember |
| Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember |
| Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember |
| Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember |
| Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Don’t know or remember |

## Knowledge, attitudes, and practices

1. In the last 4 weeks, how often have you left the home to go to the following places:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Occasionally  (1-3 times) | ~Once/week | Few times/week | Almost everyday/ everyday |
| grocery store | [ ] | [ ] | [ ] | [ ] | [ ] |
| restaurant (pick-up only) | [ ] | [ ] | [ ] | [ ] | [ ] |
| restaurant (dine in) | [ ] | [ ] | [ ] | [ ] | [ ] |
| retail store | [ ] | [ ] | [ ] | [ ] | [ ] |
| pharmacy/get medication | [ ] | [ ] | [ ] | [ ] | [ ] |
| seek medical care | [ ] | [ ] | [ ] | [ ] | [ ] |
| outdoors (walking, physical activity) | [ ] | [ ] | [ ] | [ ] | [ ] |
| work | [ ] | [ ] | [ ] | [ ] | [ ] |
| home of a family member | [ ] | [ ] | [ ] | [ ] | [ ] |
| home of a friend | [ ] | [ ] | [ ] | [ ] | [ ] |
| church/place of worship | [ ] | [ ] | [ ] | [ ] | [ ] |
| other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] | [ ] | [ ] | [ ] | [ ] |

1. Currently, how concerned are you about you or your family getting sick with COVID-19?

[ ] Very concerned [ ] Somewhat concerned [ ] Not concerned at all

1. As far as you are aware, what does the shelter-in-place order mean?

(*Do not read options - Select all options the participant mentions.)*

[ ] People should stay home unless conducting essential business

[ ] Non-essential businesses should be closed

[ ] Restaurants can do take-away/delivery only

[ ] People should stay 6 ft. away from each other

[ ] Don’t gather in large groups of people

[ ] Outside exercise is OK if stay at least 6 ft apart from other people

[ ] Other option not mentioned above, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *[Only ask this question of participants ≥18 years old]*:

In each of the following areas, how have the social distancing and/or shelter-in-place policies impacted you? Please respond to each option using the following scale (*read scale to participant*):

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Very negatively | Somewhat negatively | Neither negatively nor positively | Somewhat positively | Very positively | Does not know |
| Emotional/mental wellbeing (e.g. anxiety, depression, cabin fever, stress, etc.) | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Physical wellbeing | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Finances | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Access to essential goods/services (e.g. groceries, household needs etc.) | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |
| Access to medical care (non-COVID related) | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |

1. What actions are you taking to prevent transmission or becoming sick with the coronavirus (also known as COVID)?

[ ] Hand washing

[ ] wearing a mask

[ ] staying 6 feet from non-household members

[ ] staying at home (except for essential trips)

[ ] other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you hear about this survey before we came to your house today?

[ ] Yes [ ] No [ ] Don’t know

1. If **YES**, how did you hear about this study?

[ ] Local news channel [ ] Newspaper (print or online) [ ] Radio/NPR

[ ] Nextdoor app [ ] Social media [ ] Doorhangers

[ ] Street signs [ ] Family, friend, or neighbor

[ ] Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 

# Specific illness episodes

Please complete the following questions if the participant has indicated that they were sick more than one time between January 2020 and now with an illness that included **fever**, **cough**,or **difficulty breathing**.

Please complete this form for any illness in addition to the first illness that was indicated on the main questionnaire.

Individual ID #\_\_\_\_\_\_\_\_\_\_\_\_ (xxx.xx)

Illness episode #: \_\_\_\_\_\_\_\_\_\_\_\_

1. When was the first day that you began to feel sick (use calendar)? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Precise date cannot be recalled

If the precise date cannot be recalled, please give month \_\_\_\_\_\_\_ and year \_\_\_\_\_\_\_\_ and select one of the following: [ ] First half of month [ ] Second half of month [ ] Date unknown

1. When was the first day that you began to feel well again (use calendar)? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

[ ] Precise date cannot be recalled

If the precise date cannot be recalled, please give month \_\_\_\_\_\_\_ and year \_\_\_\_\_\_\_\_ and select one of the following: [ ] First half of month [ ] Second half of month [ ] Date unknown

1. During the time that you were sick, which of the following symptoms did you have?

* Fever measured by thermometer [ ] Yes [ ] No [ ] Don’t know

If **YES**, maximum recorded temperature: \_\_\_\_\_\_\_ F / C

* Felt feverish [ ] Yes [ ] No [ ] Don’t know
* Chills [ ] Yes [ ] No [ ] Don’t know
* Cough [ ] Yes [ ] No [ ] Don’t know
* Sore throat [ ] Yes [ ] No [ ] Don’t know
* Runny or stuffy nose [ ] Yes [ ] No [ ] Don’t know
* Difficulty breathing [ ] Yes [ ] No [ ] Don’t know
* Muscle pain [ ] Yes [ ] No [ ] Don’t know
* Chest pain [ ] Yes [ ] No [ ] Don’t know
* Abdominal pain [ ] Yes [ ] No [ ] Don’t know
* Nausea/vomiting [ ] Yes [ ] No [ ] Don’t know
* Diarrhea [ ] Yes [ ] No [ ] Don’t know
* Headache [ ] Yes [ ] No [ ] Don’t know
* Fatigue [ ] Yes [ ] No [ ] Don’t know
* Loss of sense of smell or taste [ ] Yes [ ] No [ ] Don’t know
* Other (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] Yes [ ] No [ ] Don’t know

1. Did you go to a doctor, clinic, or emergency room because of this illness?

[ ] Yes [ ] No (skip to 8) [ ] Don’t know or can’t remember

1. Did you stay overnight in the hospital for this illness?

[ ] Yes [ ] No [ ] Don’t know or can’t remember

1. If **YES**, for how many days were you hospitalized? \_\_\_\_\_\_\_\_ days
2. How many days after your symptoms started were you admitted to hospital? \_\_\_\_\_\_\_\_ days
3. Do you remember the dates?

Hospital admission \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

Hospital discharge \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ (mm/dd/yyyy)

1. If **YES** to question ‎6, did you receive a diagnosis for this illness??

[ ] Yes [ ] No [ ] Don’t know or can’t remember

1. If **YES**, please specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Did you miss any days of school or work because of this illness?

[ ] Yes [ ] No [ ] Don’t know/remember

A. If **YES**, how many days of school or work did you miss? \_\_\_\_\_\_\_\_ days

1. While you were sick, how often did you go to public places (e.g., school, work, store, place of worship) during the 7 days after your illness began except for visiting the doctor?

[ ] Multiple times per day [ ] Once per day [ ] Several times during the 7-day period

[ ] Rarely [ ] Never [ ] Don’t know

1. While you were sick, did any family or friends come over to visit you?

[ ] Yes [ ] No [ ] Don’t know