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Attachment 3a – Individual Questionnaire

Form Approved
OMB No. 0920-XXXX
Exp. Date: xx/xx/2020

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 14.2..)

   A. Were you sick more than one time between January and now?
   [ ] Yes [ ] No [ ] Don't know or can't remember

   B. If **YES**, how many times were you ill? ___ times

   (If **YES,** please complete questions 3. – 17. for the first illness episode and complete **Sub-appendix 1** for each subsequent illness episode.)

   C. Are you **currently** having fever, cough, or difficulty breathing?
   [ ] Yes [ ] No [ ] Don't know
   (Skip to section, "Specific illness episode14."14..)

2. 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 14.14..)
   A. If **YES**, on approximately which date were you tested? ____/____/_____ (mm/dd/yyyy)
   [ ] Don't know or can't remember

B. What was your test result?
[ ] Positive [ ] Negative [ ] Have not received test result [ ] Don't know
(Skip to question 14.14..)

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.

3. 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 _____

4. 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 _____

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

• Fever measured by thermometer If **YES**, maximum recorded temperature: _____ F / C	[ ] Yes	[ ] No	[ ] Don't know
• 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

6. 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

7. Did you stay overnight in the hospital for this illness?
[ ] Yes [ ] No [ ] Don't know or can't remember

A. If **YES**, on which date were you admitted to the hospital? ____/____/_____ (mm/dd/yyyy)

B. For how many days were you hospitalized? _____ days

8. If **YES** to question 7., did you receive a diagnosis for this illness??
[ ] Yes [ ] No [ ] Don't know or can't remember

A. If **YES**, please specify? _____

9. Were you tested for influenza/flu?
[ ] Yes [ ] No [ ] Don't know
A. If **YES**, on approximately which date were you tested? ____/____/_____ (mm/dd/yyyy)
[ ] Don't know or can't remember

B. If **YES,** what was your test result?
[ ] Positive [ ] Negative [ ] Have not received test result [ ] Don't know

10. Were you tested for SARS-CoV-2 (also called COVID-19)?
[ ] Yes [ ] No [ ] Don't know
A. If **YES**, on approximately which date were you tested? ____/____/_____ (mm/dd/yyyy)
[ ] Don't know or can't remember

B. If **YES**, what was your test result?
[ ] Positive [ ] Negative [ ] Have not received test result [ ] Don't know

11. 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

12. 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

13. While you were sick, did any family or friends come over to visit you?
[ ] Yes [ ] No [ ] Don't know

Medical history

14. 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 _____)

15. Are you currently pregnant or have you had a child within the last 6 weeks?
[ ] Yes [ ] No [ ] Don't know [ ] Not applicable

16. Are you currently breastfeeding?
[ ] Yes [ ] No [ ] Don't know [ ] Not applicable

17. If the household member is a young child, is he/she/they currently being breastfed?
[ ] Yes [ ] No [ ] Don't know [ ] Not applicable

Employment

18. Do/did you attend or work in a school or daycare?
[ ] Yes [ ] No [ ] Don't know

A. If **YES**, last date that you were in the school or daycare: ____/_____/_____ [ ] Still working in/going to daycare

19. 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)
_____

A. 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."

20. Do you work at a place that is considered an "essential service"?
[ ] Yes [ ] No [ ] Don't know

A. 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
[ ] Delivery driver, parcel (e.g., USPS, UPS, Fedex)
[ ] Public transportation/airline/airport
[ ] Government/public service
[ ] Delivery driver, food (e.g., grocery, restaurant, Uber Eats)
[ ] Other:_____

21. 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
A. What is your occupation? _____
B. If **TELEWORKING or FURLOUGHED/LOST JOB**, what is the last date that you worked outside of your home?
____/_____/_____

Exposures

22. 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
A. If **YES**, what was the last date of contact? ____/____/_____ [ ] Don't know

B. 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):_____

C. Did you take care of this/these person(s)?
[ ] Yes [ ] No [ ] Don't know

23. 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
A. If **YES**, when was the last date of contact? ____/____/_____ [ ] Don't know

B. 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):_____

24. Have you traveled out of the state or country since January 2020?
[ ] Yes [ ] No [ ] Don't know

A. If **YES**, how many trips? _____ trips

Travel

B. 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

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

Knowledge, attitudes, and practices

25. 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) _____	[ ]	[ ]	[ ]	[ ]	[ ]

26. Currently, how concerned are you about you or your family getting sick with COVID-19?
[ ] Very concerned [ ] Somewhat concerned [ ] Not concerned at all

27. 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 _____

28. *[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)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

29. 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) _____

30. Did you hear about this survey before we came to your house today?
[ ] Yes [ ] No [ ] Don't know

A. 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 #: _____

4. 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

5. 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

6. 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

7. 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

8. Did you stay overnight in the hospital for this illness?
[ ] Yes [ ] No [ ] Don't know or can't remember

C. If **YES**, for how many days were you hospitalized? _____ days

D. How many days after your symptoms started were you admitted to hospital? _____ days

E. Do you remember the dates?
Hospital admission ____/____/_____ (mm/dd/yyyy)

Hospital discharge ____/____/_____ (mm/dd/yyyy)

9. If **YES** to question 7., did you receive a diagnosis for this illness??
[ ] Yes [ ] No [ ] Don't know or can't remember

B. If **YES**, please specify? _____

10. 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

11. 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

12. While you were sick, did any family or friends come over to visit you?
[ ] Yes [ ] No [ ] Don't know