Form Approved

OMB No. 0920-XXXX

Exp. Date: xx/xx/2020

COVID-19 Community Seroepidemiological Investigation

# Household Questionnaire

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

Team #\_\_\_\_\_\_ Cluster ID #\_\_\_\_\_\_\_ Census Block ID #: \_\_\_\_\_\_\_\_\_\_\_\_ Household ID #\_\_\_\_\_\_\_\_\_\_\_

Date (1st visit) \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Date (2nd visit) \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

(mm/dd/yyyy) (mm/dd/yyyy)

## Household characteristics

1. Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latitude: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Longitude: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Type of dwelling

[ ] Single family (1 housing unit in building; including townhouses)

[ ] Multi-family (2-10 housing units in building)

[ ] Apartment/condo building (>10 housing units in building)

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

3. What is the primary language spoken in the household?

[ ] English [ ] Spanish [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many people live in this household? \_\_\_\_\_\_\_\_\_\_\_ people

*A household member is defined as* *an individual who spends an average of ≥2 nights per week in the home.*

CDC estimates the average public reporting burden for this collection of information as 15 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).

## Household members

1. Please answer the following questions for each member of the household

| **Person#** | **Individual ID#**  **(CSID)** | **Age \*** | **Age unit**  (circle) | **Sex**  (circle) | **Race** †  (1-5, 9) | **Ethnicity** †  (1, 2,9) | **Present Visit 1**  (circle) | **Present Visit 2**  If No at visit 1  (circle) | **Interviewed**  (circle) | **Blood collected**  (circle) | **Had symptoms** ‡ **since Jan 2020 ?**  (circle) | **Tested for flu?§** (circle) | **Tested for COVID-19?§** (circle) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **01** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **02** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **03** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **04** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **05** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **06** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **07** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **08** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **09** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |
| **10** |  |  | Y M | M F Other |  |  | Y N | Y N | Y N | Y N | Y N  Unk | NT NR  Pos Neg | NT NR  Pos Neg |

\* If newborn aged <1 month, age is 0 and unit is “M.”

† **Race codes Ethnicity codes**

1 White 4 Native Hawaiian or Other Pacific Islander 1 Hispanic

2 Black 5 American Indian or Alaska Native 2 Non-Hispanic

3 Asian 9 Unknown/Other 9 Unknown/Other

‡ Symptoms include **fever**, **cough**,or **difficulty breathing**.

§ **Covid-19 test codes**

NT Not tested Pos Tested positive

NR Tested, no result Neg Tested negative

1. Have you had any visitors spend one or more nights in your home since January 2020?

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

## Visitors

If **YES**, visited from:

| **Visited from** (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 |