



# Human Infection with 2019 Novel Coronavirus (nCoV) Household Contact Questionnaire V1.5 rev 3/24/2020 (Household Transmission Investigation)

State: WI

Household ID: WI-\_\_\_\_\_

Study ID: WI-\_\_\_\_\_

This questionnaire is to be administered to each household member (excluding the index patient).

### Interview Information

1. Date of Interview: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)
2. Name of Interviewer: \_\_\_\_\_
3. Person completing the interview:  Self  Parent/guardian: \_\_\_\_\_  
 Other: \_\_\_\_\_

### Household Member Information

4. Household member's name: First: \_\_\_\_\_ Last: \_\_\_\_\_
5. Date of birth: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)
6. Age: \_\_\_\_\_  years  months  days
7. Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Not Specified
8. Race:  White  Black  Asian  
 Am Indian/Alaska Nat  Nat Hawaiian/Other PI  Other, specify: \_\_\_\_\_  Unknown
9. Sex:  Male  Female
10. What is your relationship to [insert name of index patient]?  
 Spouse  Child  Parent  Grandparent  Sibling  Employee  Other  
\_\_\_\_\_
11. What is the highest level of education you have completed?  
 Less than high school  
 High school diploma/GED  
 Some college credit, no degree  
 Technical degree/Associate's degree  
 Bachelor's degree (i.e., B.A., B.S.)  
 Master's degree (i.e., MBA)  
 Doctorate or professional degree

12. What is your occupation? \_\_\_\_\_

### SARS-CoV-2 testing for household contacts

13. Have you been tested for coronavirus?  Yes  No  
If yes, please complete the following information:
  - a. Date of specimen collection \_\_\_\_\_ (MM/DD/YYYY)
  - b. Result of test:  Positive  Negative  Pending  Don't know/other \_\_\_\_\_
  - c. Date of test result \_\_\_\_\_ (MM/DD/YYYY)
  - d. Were you experiencing symptoms when you were tested?  Yes  No
    - i. Describe: \_\_\_\_\_
  - e. Date of symptom onset: \_\_\_\_\_ (MM/DD/YYYY)

Notes: \_\_\_\_\_



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**Past Medical History**

14. Please provide pre-existing medical conditions (complete regardless of age):

Asthma/reactive airway disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Active tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, on treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Any other chronic lung diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Hypertension (high blood pressure)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Coronary artery disease/heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Any other heart diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Any kidney disorders? If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
End-stage renal disease/dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Renal insufficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other kidney diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Any liver disorders? If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Alcoholic liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cirrhosis/End stage liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other chronic liver diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
HIV infection. If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
AIDS or CD4 count currently <200	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Ever receive a transplant? If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Solid organ transplant				If YES, date: _____
Stem cell transplant (e.g., bone marrow transplant)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, date: _____
Cancer: current/in treatment or diagnosed in last 12 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Immunosuppressive therapy/medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____ For what condition: _____
Other immunosuppressive conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Any other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____



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Developmental or neurologic disorder. If YES, answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Chromosomal or genetic abnormality	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Cerebral palsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Any other development or neurologic Disorder				If YES, specify: _____
Any other medical conditions as a child	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If YES, specify: _____
Were you born premature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, gestation at birth: _____ wks

15. [If female] Are you currently pregnant?  Yes  No  Unknown  N/A
16. [If female] Are you postpartum (≤6 weeks postpartum)?  Yes  No  Unknown  N/A
17. [If female] Are you breastfeeding?  Yes  No  Unknown  N/A
18. [If child <3 years] Is your child being breastfed?  Yes  No  Unknown  N/A

### Smoking/Vaping

19. Do you currently smoke tobacco on a daily basis, less than daily, or not at all?  
 Daily  Less than daily  Not at all  Unknown
20. [If not a daily smoker] In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?  
 Daily  Less than daily  Not at all  Unknown
21. Do you currently vape or use electronic cigarettes on a daily basis, less than daily, or not at all?  
 Daily  Less than daily  Not at all  Unknown

### Symptoms Prior to Index Case's Onset

*Note to interviewer: record symptom onset date of the index patient from household questionnaire cover sheet. Ask the interviewee to get a calendar or personal diary. \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)*

22. Did you experience any symptoms of a respiratory illness in the **2 weeks prior** to [insert name of index patient] becoming ill?  
 Yes  No  Unknown

### Exposures Outside of the Household

*Note to interviewer: remind the interviewee to consult a calendar or diary for the following questions.*

*Date of index patient symptom onset: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)*

*14 days prior to index patient's symptom onset: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)*

23. **Since [14 days PRIOR to the index patient's symptom onset]...**

Exposure	Answer
...have you traveled (internationally or within the U.S., or on a cruise)?	<input type="checkbox"/> Yes: with index patient <input type="checkbox"/> Yes: w/o index patient <input type="checkbox"/> No <input type="checkbox"/> Unknown
...attend a mass gathering (e.g., religious event, wedding,	<input type="checkbox"/> Yes: with index patient <input type="checkbox"/> Yes: w/o index patient



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party, dance, concert, banquet, festival, sports event, or other events)?	<input type="checkbox"/> No <input type="checkbox"/> Unknown
...have close contact (e.g. caring for, speaking with, touching, physically within 6 feet) with any suspected or known COVID-19 case outside of the household?	<input type="checkbox"/> Yes: with index patient <input type="checkbox"/> Yes: w/o index patient <input type="checkbox"/> No <input type="checkbox"/> Unknown
...work in a healthcare setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, what types of healthcare settings: <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Dental Clinic <input type="checkbox"/> Dialysis Center <input type="checkbox"/> ICU <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Other, specify: _____  What type of job do you have at the healthcare setting? <input type="checkbox"/> Admin staff <input type="checkbox"/> Nurse/Nurse tech <input type="checkbox"/> Doctor <input type="checkbox"/> EMS <input type="checkbox"/> Other, specify: _____
...visit a healthcare setting (e.g. visit someone or have an appointment -- at a hospital, ED, outpatient clinic, dental clinic, long-term care facility)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...attend/work at a daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...attend/work at a school?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

### Symptoms After the Index Case's Onset

*Note to interviewer: record symptom onset date of the index patient from household questionnaire. Ask the interviewee to get a calendar or personal diary. \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)*

24. Since ___/___/___, when [the index case] first became symptomatic, have you experienced any of the following symptoms?	Symptom Present?
Fever >100.4F (38C) <sup>c</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk



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24. Since ___/___/___, when [the index case] first became symptomatic, have you experienced any of the following symptoms?	Symptom Present?		
Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Other, specify:			

25. What date did you **first** become symptomatic?  
\_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

26. Are you currently experiencing any symptoms of a respiratory illness, such as fever, cough, or shortness of breath?  
(Note: Flag any symptomatic household members for workflow planning and offer of self-nasal swab during visit)  
 Yes  No  Unknown

### Exposures to the Index Patient

Note to interviewer: record symptom onset date of the index patient from household questionnaire. Ask the interviewee to get a calendar or personal diary. \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

27. Since [index case]'s symptoms started on [date of symptom onset of the index patient], did you .....?

Exposure	Answer
...spend more than 10 minutes within 6 feet of the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...have face to face contact with the index patient (i.e., within about 2 feet)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...spend any time within 6 feet of the index patient while he/she was coughing or sneezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...shake hands with the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...hug the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...kiss the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...take an object handed from or handled by the index patient? (e.g., pen, paper, food, utensil, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
...sleep in the same bedroom as the index patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown



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Exposure	Answer		
...sleep in the same bed as the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...share a bathroom with the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...prepare food with the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...share meals with the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...eat from the same plate as the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...share a utensil with the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...share a drinking cup/glass with the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
...travel in the same vehicle (car, bus, airplane), sitting within 6 feet of the index patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

28. Did you serve as primary caretaker for the index patient while he/she was ill?  Yes  No  Unknown

29. When was your last exposure (*include any exposures described above*) to [*name of the index patient*]?  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)  Ongoing exposure

30. How many days have you spent in the household since [*date of symptom onset of index patient*]? \_\_\_\_\_

31. How many nights have you spent in the household since [*date of symptom onset of index patient*]? \_\_\_\_\_