

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ___/___/_____

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....



COVID-19 Case Interview Form

Record ID: CO _____

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____

Telephone _____ Email _____

Date of interview: _____ (MM/DD/YYYY)

Data sources used for this form?

Case-patient interview Other interview, specify relationship to case: _____ Case Report Form/CEDRS

Case-patient's primary language: _____ Was this form administered via a translator? Yes No Unknown

Case-patient demographic information

1. Report date to CDPHE: ___/___/_____
2. Under what process was the case first identified? (check all that apply): Sought care for acute illness Contact tracing of case patient Unknown Other, specify: _____
3. Date of birth (month and year): Month _____ Year _____
4. Age: _____ Age units: Years Months Days
5. Sex: Male Female
6. Ethnicity: Hispanic/Latino Non-Hispanic/Latino Not specified
7. Race (check all that apply): White Asian American Indian/Alaska Native Black Native Hawaiian/Other Pacific Islander Unknown Other, specify: _____
8. County of Residence: _____ State of Residence: _____
9. Country of Residence: United States Other, specify _____
10. Occupation: _____
 Are you currently employed in a laboratory that processes COVID-19 samples? Yes No
 If student, what grade level? _____
 If child, does s/he attend day care? Yes No Unknown

Travel history

11. In the 14 days prior to illness onset, were you traveling away from your home internationally?
 Yes No Unknown
12. In the 14 days prior to illness onset, were you traveling away from your home within the United States?
 Yes No Unknown
13. If "yes" to Q11 or Q12: Where did you travel 14 days prior to illness onset (list **ALL** locations, including overnight transits and layovers)?

	Departure Date (MM/DD/YYYY)	Departure city, state/province/country	Arrival Date (MM/DD/YYYY)	Arrival city, state/province/country
Trip 1				
Trip 2				
Trip 3				
Trip 4				



COVID-19 Case Interview Form

Trip 5			
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Exposure history

14. In the **14 DAYS prior to illness**, did you have close contact with another lab-confirmed COVID-19 case-patient?

Yes No Unknown Date Range: Start Date (MM/DD/YYYY) _____ End Date (MM/DD/YYYY) _____

15. Relationship to COVID-19 **source** case (select all that apply):

Spouse/Partner Child Parent Other Family Friend HCW Co-worker
 Classmate Roommate Contact only - no relationship Other (specify): _____

16. Exposure setting to the COVID-19 **source** case (select all that apply):

Household Work Daycare School/University Transit Rideshare Hotel Cruise Ship
 Healthcare Other (specify): _____

17. In the **14 DAYS prior to illness onset**, did you:

Exposure	Answer	Date Range
...have any household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (e.g. cough, sore throat etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have close contact (e.g. caring for, speaking with, or touching) with any ill persons?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...use public transportation (bus, train, airplane)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...attend or work at a school or daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have a household member who attended school or daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have close contact (e.g. caring for, speaking with, or touching) with a sick person who had contact with a COVID-19 patient (i.e., secondary contact to confirmed case)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
...have close contact (e.g. caring for, speaking with, or touching) with a person who had a fever and/or acute respiratory illness AND international travel in the past 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes where did the person travel: _____	

18. In the **14 DAYS prior to illness onset**, did you:

Exposure	Y/N/Unk	Facility type (Select all that apply)	Date(s) exposure occurred
Work in healthcare setting:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk If yes, what was your role: <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Administration staff	<input type="checkbox"/> Hospital <input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Urgent Care <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Doctor's office/clinic <input type="checkbox"/> Other (specify)	

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	<input type="checkbox"/> Housekeeping <input type="checkbox"/> Patient transport <input type="checkbox"/> Other, specify _____		
Volunteer in healthcare setting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Have direct patient contact	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Visit healthcare setting as a patient (not just for this illness)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Visit healthcare setting for any reason other than as a patient	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)
Contact with a known COVID-19 case-patient in a healthcare setting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk If yes, as a <input type="checkbox"/> Patient <input type="checkbox"/> Visitor <input type="checkbox"/> HCW	<input type="checkbox"/> Hospital <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's office/clinic	<input type="checkbox"/> Dialysis unit/center <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other (specify)

19. Do you reside in a facility or group setting (e.g. long-term care facility/nursing home, boarding school, college dormitory, etc.)?

Yes No Unknown

If yes, what type of group setting do you live in? Military base Shelter Nursing home/long-term healthcare facility

Assisted Living Facility Hospice School dormitory Homeless Detention/correctional facility

Foster care group setting Other: _____

20. If they answered "No" to question 19: How many people in total resided in your household (HH) from the 14 days prior to illness through the date of this interview (excluding you)? _____. A household member is anyone with at least one overnight stay during the 14 days prior to patient's illness onset to the date of this interview. If patient belongs to multiple HH, group HH members by identifying the 1st HH as A, the 2nd HH as B, etc.

HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the 14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness?	Date of illness onset of household member (MM/DD/YYYY)
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	

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HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the 14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness?	Date of illness onset of household member (MM/DD/YYYY)
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	

Symptoms

21. What was the onset date of your first symptom (MM/DD/YYYY): ___/___/___ Unknown
22. Are you still having symptoms? Still symptomatic Symptoms resolved Not applicable (patient deceased) Unknown

If symptoms resolved, date of symptom resolution (MM/DD/YYYY): ___/___/___ Unknown

23. What was the first symptom you experienced? _____
24. If you received medical care for this illness, what symptom(s) prompted your visit to the doctor or other healthcare professional?
 _____ Did not receive medical care
25. During this illness, did you experience any of the following symptoms? (for each symptom experienced, ask what date that symptom started and how many days that symptom lasted to complete the table below)

Symptom	Symptom Present?	Date of Onset (MM/DD/YY)	Duration (no. of days)
Fever >100.4F (38C)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Highest temp _____ °F			
Subjective fever (felt feverish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Dehydration	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Dry	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Productive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Bloody sputum (hemoptysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Stuffy nose (nasal congestion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

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Symptom	Symptom Present?	Date of Onset (MM/DD/YY)	Duration (no. of days)
Loss of smell (Anosmia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Loss of taste (Ageusia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Swollen Lymph Nodes (Lymphadenopathy)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Eye redness (conjunctivitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Loss of appetite (anorexia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Diarrhea (>3 loose stools/day)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Joint Pain (Arthralgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Altered Mental Status (confusion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Past medical history

26. Do you have any pre-existing medical conditions?

Yes No Unknown

Chronic Lung Disease: Do you have any lung or breathing problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Asthma/reactive airway disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Emphysema/Chronic Obstructive Pulmonary Disease (COPD)/Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Interstitial lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pulmonary fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Restrictive lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sarcoidosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Chronic hypoxemic respiratory failure with O2 requirement (Do you use oxygen at home?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Obstructive sleep apnea (OSA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other chronic lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Active tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cardiovascular (CV) disease: Do you have any heart or blood vessel problems?	<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
Heart failure/Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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Cerebrovascular accident/Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Congenital heart disease (childhood heart problem)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Valvular Heart Disease (abnormal heart valve[s] – e.g., aortic stenosis, mitral regurgitation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Arrhythmia (abnormal/irregular heartbeat or rhythm)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other CV disease (e.g. peripheral artery disease, aortic aneurysm, cardiomyopathy, or other heart or vessel diseases specified by the patient)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Endocrine disorder: Do you have any hormone problems, like diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Diabetes Mellitus (DM)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, specify DM Type 1 or 2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, what level was your last HgA1c? (Hemoglobin A1c or “A1c”)? _____ Date (MM/YY) _____			<input type="checkbox"/> Unknown
Pre-diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, what level was your last HgA1c? (Hemoglobin A1c or “A1c”)? _____ Date (MM/YY) _____			<input type="checkbox"/> Unknown
Other endocrine (hormone) disorder (e.g. pituitary problems, hyperthyroidism, hypothyroidism, Addison’s disease, Cushing’s syndrome)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Renal disease: do you have any kidney problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Chronic kidney disease/insufficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
End-stage renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, specify type: hemodialysis (HD) or peritoneal	<input type="checkbox"/> HD	<input type="checkbox"/> Peritoneal	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Liver disease: do you have any liver problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Alcoholic hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Chronic 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
Hepatitis B, chronic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hepatitis C, chronic	<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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Autoimmune disorders: do you have any autoimmune diseases? These include diseases such as...(read below conditions)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Systemic lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			

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Hematologic disorders: do you have any blood problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Sickle cell disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sickle cell trait	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Bleeding or clotting disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Other hematologic (blood) disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Immunocompromised Condition: do you have any conditions or diseases that make you more prone to infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
HIV infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, what was your last CD4 Count? _____ Date (MM/YY) _____			<input type="checkbox"/> Unknown
AIDS or CD4 count <200	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Solid organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Stem cell transplant (e.g., bone marrow transplant)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Lymphoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Multiple myeloma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Splenectomy/asplenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Cancer: have you had, or do you have, cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <i>(skip to next section)</i>	<input type="checkbox"/> Unknown <i>(skip to next section)</i>
If yes, what type of cancer? _____			
What year did you were you diagnosed? _____			
Did your cancer treatment include any of the following? <i>(If yes, specify what years you received treatment)</i>			
IV Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Oral chemotherapy (pills)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Radiation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Year(s): _____			
Neurologic/neurodevelopmental disorder: do you have any diseases of the brain, spinal cord, or nerves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			
Psychiatric Diagnosis: do you have any mental health problems? (e.g. depression, bipolar disorder,	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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anxiety disorder, schizophrenia)			
If Yes, specify: _____			
Other chronic diseases:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, specify: _____			

27. Current height: _____ (inches) OR _____ (cm)
28. Current weight: _____ (pounds) OR _____ (kg)
29. Do you use or depend on any of the following?
- Feeding tube Yes No Unknown
- Tracheostomy Yes No Unknown
- Wheelchair Yes No Unknown
- Walker Yes No Unknown
30. Are you bed-ridden? Yes No
31. If female, are you currently pregnant? Yes Weeks pregnant at illness onset _____ No Unknown
32. If female, are you postpartum (≤6 weeks postpartum)? Yes No Unknown
33. If currently pregnant or postpartum, have you had or did you have any complications during this pregnancy?
- None Gestational diabetes Pre-eclampsia Pregnancy-induced hypertension (PIH) Intrauterine growth restriction (IUGR)
- Other, specify: _____
34. If female, are you breastfeeding? Yes No Unknown
35. If child, is he/she being breastfed? Yes No Unknown
36. Do you have health insurance? Yes No Unknown
- If yes, what kind of health insurance do you have? Private Medicare Medicaid Indian Health Service (IHS)
- Military (Tricare) Incarcerated Unknown/Did not want to answer

Medication history

The next several questions will ask about medications. First, I would like to know all medications taken **during the month before your illness began, and then I will ask about all medications taken during your COVID-19 illness (*up to hospitalization)**. We are interested in all medications, including prescriptions, inhalers, over the counter medications, vitamins, supplements, and herbs. If you have a list or container of medications, including any inhalers please get that now. Let me know when you're ready to begin

37. **During the month before your illness began**, what types of medications did you take for underlying conditions, including prescriptions, inhalers, over the counter medications, vitamins, supplements, and herbs?
- Do you take any medications for high blood pressure, pain, or fever? *(If yes, ask questions to fill in table below – example prompting questions and abbreviation definitions are in the SOP)*
- How about for infections caused by fungus, bacteria, or viruses? *(If yes, ask questions to fill in table below)*
- How about any medications that may weaken your immune system and ability to fight infections? These medications are often used to treat autoimmune disorders or inflammation. *(If yes, ask questions to fill in table below)*
- Do you use an inhaler? *(If yes, ask questions to fill in table below)*
- Any other medications you may have forgotten? *(If yes, ask questions to fill in table below)*

Did not take any medications in the month before COVID-19 illness began

Medication Name	Route	Frequency	Continued to take during illness?
	<input type="checkbox"/> PO <input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Topical <input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

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	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			

****If more than 6 medications listed by patient please fill out additional medication section at the end of the questionnaire.****

38. **During your COVID-19 illness**, did you take any medications **other than the medications we covered in the previous section**? This includes prescriptions, inhalers, over the counter medications, vitamins, supplements, and herbs. **If you were hospitalized for this illness**, we only need to know about medications taken up until you were hospitalized. (Prompting questions to fill in table as well as abbreviation definitions can be found in the SOP)

- Do you take any medications for pain or fever? (If yes, ask questions to fill in table below)
- Did you take any medications for cold or flu symptoms? (If yes, ask questions to fill in table below)
- Were you prescribed any medication by a Healthcare Provider? (If yes, ask questions to fill in table below)
- Did you take any other medications? (If yes, ask questions to fill in table below)

Did not take any medications during illness (except any mentioned above).

Medication Name	Route	Frequency	Duration
	<input type="checkbox"/> PO <input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	_____ days
	<input type="checkbox"/> Topical <input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	
Indication: _____			
	<input type="checkbox"/> PO <input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	_____ days
	<input type="checkbox"/> Topical <input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	

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	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	_____ days
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	_____ days
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	_____ days
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			
<input type="checkbox"/> PO	<input type="checkbox"/> Injection	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD	_____ days
<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
Indication: _____			

****If more than 6 medications listed by patient please fill out additional medication section at the end of the questionnaire.****

39. If Chloroquine was listed as a medication taken: What dose of Chloroquine did you take? _____ unit: _____ Unknown

Social history

40. Do you currently smoke cigarettes? Yes No Unknown
 If yes, how many packs of cigarettes per day? _____ For how many years? _____
41. Have you ever smoked cigarettes? Yes No Unknown
 If yes, how many packs of cigarettes per day? _____ For how many years? _____ How long since you last smoked a cigarette? ___(m) ___(y)
42. Do you currently use e-cigarettes/vape-pen? Yes No Unknown
43. In the past year, how often did you have a drink containing alcohol?
 Never Monthly or less 2-4 times a month 2-3 times per week 4 or more times per week

The next several questions will ask about substance use. As a reminder, **this information will remain private.**

44. Do you currently use any of the following recreational drugs?

What substance do you use? (check all that apply)	Around how many times in the month prior to becoming sick did you use?	Did you use while sick with COVID-19?
<input type="checkbox"/> Marijuana/THC		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown
If yes, do you inhale or consume THC/marijuana? (check all that apply)		<input type="checkbox"/> Inhale <input type="checkbox"/> Consume
<input type="checkbox"/> Cocaine		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown
<input type="checkbox"/> Heroin		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown

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<input type="checkbox"/> Methamphetamine ("Meth")		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown
<input type="checkbox"/> Other: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown
<input type="checkbox"/> Other: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown
<input type="checkbox"/> Other: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, more than usual <input type="checkbox"/> Yes, the same amount <input type="checkbox"/> Yes, but less than usual <input type="checkbox"/> Unknown

Course of Illness

45. Did you miss work or school for this illness? Yes No Unknown
 If yes, how many days during illness? _____
46. Did you receive any medical care for the illness? Yes No Unknown
47. If yes, where and which dates did you seek care after this illness started (check all that apply)? [Please add extra visit dates in 'notes' box]

<input type="checkbox"/> Doctor's office	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
Name of healthcare facility 1: _____		Facility 2: _____
<input type="checkbox"/> Emergency room	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
Name of healthcare facility 1: _____		Facility 2: _____
<input type="checkbox"/> Retail store/pharmacy	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
<input type="checkbox"/> Health department	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
<input type="checkbox"/> Urgent care	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
Name of healthcare facility 1: _____		Facility 2: _____
<input type="checkbox"/> Telephone triage line	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
Name of healthcare facility 1: _____		Facility 2: _____
<input type="checkbox"/> Telemedicine	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
Name of healthcare facility 1: _____		Facility 2: _____
<input type="checkbox"/> Other _____	Date 1: ____/____/____ (MM/DD/YYYY)	Date 2: ____/____/____ (MM/DD/YYYY)
Name of healthcare facility 1: _____		Facility 2: _____
<input type="checkbox"/> Unknown		

48. Did you have any imaging such as an X-ray or CT for this illness? Yes No Unknown
49. Did you have any blood tests done for this illness? Yes No Unknown
50. Were you hospitalized for this illness? Yes No Unknown
 If yes, were you hospitalized because of how unwell you were or for another reason such as isolation (to prevent spread of disease)?
 Unwell Isolation Other: _____

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Additional Medications (if needed):

MAKE SURE TO CHECK WHETHER THIS IS A MEDICATION TAKEN PRIOR TO ONSET (Q37) OR AFTER SYMPTOM ONSET (Q38)

*fill out this variable only for medications from Q37

^fill out this variable only for medications from Q38

Medication Name	Route	Frequency	Continued to take during illness?*	Duration^
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____			
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____			
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____			
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____			
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____			
	<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____			

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<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____
<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown _____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____
<input type="checkbox"/> PO <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled <input type="checkbox"/> Other _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QOD <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown _____ days
<input type="checkbox"/> before onset* <input type="checkbox"/> after^	Indication: _____

Any additional comments or notes?

This is the end of the case interview. Thank you very much for your time. If you have any questions please feel free to contact the CDPHE COVID-19 helpline at 303-692-2700. If you have questions about this study, please inform them that you are a participant in the Colorado COVID-19 Case Control Study.