**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**

1. Household member’s name: First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date of birth: / / (MM/DD/YYYY)
3. Age: \_\_\_\_\_\_\_  years  months  days
4. Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Not Specified
5. Race:  White  Black  Asian

Am Indian/Alaska Nat  Nat Hawaiian/Other PI  Other, specify:\_\_\_\_\_\_\_\_\_\_\_  Unknown

1. Sex:  Male  Female
2. What is your relationship to [*insert name of index patient*]?

Spouse  Child  Parent  Grandparent  Sibling  Employee  Other \_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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

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

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

1. Have you been tested for coronavirus?  Yes  No

If yes, please complete the following information:

* 1. Date of specimen collection\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)
  2. Result of test:  Positive  Negative  Pending  Don’t know/other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  3. Date of test result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)
  4. Were you experiencing symptoms when you were tested?  Yes  No
     1. Describe:­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  5. Date of symptom onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)

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

## **Past Medical History**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Asthma/reactive airway disease | Yes | No | Unknown |  |
| Emphysema/COPD | Yes | No | Unknown |  |
| Active tuberculosis | Yes | No | Unknown | If YES, on treatment: Yes No Unknown |
| Any other chronic lung diseases | Yes | No | Unknown | If YES, specify: |
| Diabetes Mellitus | Yes | No | Unknown |  |
| Hypertension (high blood pressure) | Yes | No | Unknown |  |
| Coronary artery disease/heart attack | Yes | No | Unknown |  |
| Congestive heart failure | Yes | No | Unknown |  |
| Stroke | Yes | No | Unknown |  |
| Congenital heart disease | Yes | No | Unknown |  |
| Any other heart diseases | Yes | No | Unknown | If YES, specify: |
| Any kidney disorders? If YES, answer the following: | Yes | No | Unknown |  |
| End-stage renal disease/dialysis | Yes | No | Unknown |  |
| Renal insufficiency | Yes | No | Unknown |  |
| Other kidney diseases | Yes | No | Unknown | If YES, specify: |
| Any liver disorders? If YES, answer the following: | Yes | No | Unknown |  |
| Alcoholic liver disease | Yes | No | Unknown |  |
| Cirrhosis/End stage liver disease | Yes | No | Unknown |  |
| Chronic hepatitis B | Yes | No | Unknown |  |
| Chronic hepatitis C | Yes | No | Unknown |  |
| Non-alcoholic fatty liver disease  (NAFLD)/NASH | Yes | No | Unknown |  |
| Other chronic liver diseases | Yes | No | Unknown | If YES, specify: |
| HIV infection. If YES, answer the following: | Yes | No | Unknown |  |
| AIDS or CD4 count currently <200 | Yes | No | Unknown |  |
| Ever receive a transplant? If YES, answer the following: | Yes | No | Unknown |  |
| Solid organ transplant |  |  |  | If YES, date: |
| Stem cell transplant (e.g., bone  marrow transplant) | Yes | No | Unknown | If YES, date: |
| Cancer: current/in treatment or diagnosed in last 12 months | Yes | No | Unknown | If YES, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Immunosuppressive therapy/medications | Yes | No | Unknown | If YES, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  For what condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other immunosuppressive conditions | Yes | No | Unknown | If YES, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any other chronic diseases | Yes | No | Unknown | If YES, specify: |
| Developmental or neurologic disorder. If YES, answer the following: | Yes | No | Unknown | If YES, specify: |
| Chromosomal or genetic abnormality | Yes | No | Unknown | If YES, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cerebral palsy | Yes | No | Unknown |  |
| Epilepsy | Yes | No | Unknown |  |
| Any other development or neurologic  Disorder |  |  |  | If YES, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any other medical conditions as a child | Yes | No | Unknown | If YES, specify: |
| Were you born premature? | Yes | No | Unknown | If yes, gestation at birth:\_\_\_\_\_\_\_\_\_\_\_\_wks |

1. [*If female*] Are you currently pregnant?  Yes  No  Unknown  N/A
2. [*If female*] Are you postpartum (6 weeks postpartum)?  Yes  No  Unknown  N/A
3. [*If female*]Are you breastfeeding?  Yes  No  Unknown  N/A
4. [*If child <3 years*] Is your child being breastfed?  Yes  No  Unknown  N/A

**Smoking/Vaping**

1. Do you currently smoke tobacco on a daily basis, less than daily, or not at all?

Daily  Less than daily  Not at all  Unknown

1. [*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

1. 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)*

1. 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)*

1. **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)? | Yes: with index patient  Yes: w/o index patient  No  Unknown |
| …attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other events)? | Yes: with index patient  Yes: w/o index patient  No  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? | Yes: with index patient  Yes: w/o index patient  No  Unknown |
| …work in a healthcare setting? | Yes  No  Unknown  If yes, what types of healthcare settings:  □ Hospital  □ Outpatient Clinic  □ Emergency Dept  □ Dental Clinic  □ Dialysis Center  □ ICU  □ Long-term care facility  □ Other, specify: \_\_\_\_\_\_\_\_\_\_  What type of job do you have at the healthcare setting?  □ Admin staff  □ Nurse/Nurse tech  □ Doctor  □ EMS  □ 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)? | Yes  No  Unknown |
| …attend/work at a daycare? | Yes  No  Unknown |
| …attend/work at a school? | Yes  No  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)*

| 1. Since **\_\_\_\_/\_\_\_\_/\_\_\_\_, when [the index case] first became symptomatic, have you experienced any of the following symptoms?** | **Symptom Present?** |
| --- | --- |
| Fever >100.4F (38C)c | Yes No Unk |
| Subjective fever (felt feverish) | Yes No Unk |
| Chills | Yes No Unk |
| Muscle aches (myalgia) | Yes No Unk |
| Runny nose (rhinorrhea) | Yes No Unk |
| Sore throat | Yes No Unk |
| Cough (new onset or worsening of chronic cough) | Yes No Unk |
| Shortness of breath (dyspnea) | Yes No Unk |
| Nausea/Vomiting | Yes No Unk |
| Headache | Yes No Unk |
| Abdominal pain | Yes No Unk |
| Diarrhea (≥3 loose/looser than normal stools/24hr period) | Yes No Unk |
| Other, specify: | |

1. What date did you **first** become symptomatic?

\_\_\_ / \_\_ /\_ \_\_ (MM/DD/YYYY)

1. 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)*

1. **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? | Yes  No  Unknown |
| …have face to face contact with the index patient (i.e., within about 2 feet)? | Yes  No  Unknown |
| …spend any time within 6 feet of the index patient while he/she was coughing or sneezing? | Yes  No  Unknown |
| …shake hands with the index patient? | Yes  No  Unknown |
| …hug the index patient? | Yes  No  Unknown |
| …kiss the index patient? | Yes  No  Unknown |
| …take an object handed from or handled by the index patient? (e.g., pen, paper, food, utensil, etc.) | Yes  No  Unknown |
| …sleep in the same bedroom as the index patient? | Yes  No  Unknown |
| …sleep in the same bed as the index patient? | Yes  No  Unknown |
| …share a bathroom with the index patient? | Yes  No  Unknown |
| …prepare food with the index patient? | Yes  No  Unknown |
| …share meals with the index patient? | Yes  No  Unknown |
| …eat from the same plate as the index patient? | Yes  No  Unknown |
| …share a utensil with the index patient? | Yes  No  Unknown |
| …share a drinking cup/glass with the index patient? | Yes  No  Unknown |
| …travel in the same vehicle (car, bus, airplane), sitting within 6 feet of the index patient? | Yes  No  Unknown |

1. Did you serve as primary caretaker for the index patient while he/she was ill?  Yes  No  Unknown
2. When was your last exposure (*include any exposures described above*) to [*name of the index patient*]?

\_\_\_ / \_\_ /\_ \_\_ (MM/DD/YYYY)  Ongoing exposure

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