Form Approved: OMB: 0920-XXXX Exp. XX/XX/XXXX

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	☐ 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: _____

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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

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)?	☐ Yes: with index patient ☐ Yes: w/o index patient ☐ No ☐ Unknown
...attend a mass gathering (e.g., religious event, wedding,	☐ Yes: with index patient ☐ Yes: w/o index patient

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party, dance, concert, banquet, festival, sports event, or other events)?	☐ 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)

24. 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

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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	☐ 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:	

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?	☐ 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

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Exposure	Answer
…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

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*]? _____

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