**Record ID: CO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| Interviewer informationName 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

1. In the 14 days prior to illness onset, were you traveling away from your home internationally?

[ ]  Yes [ ]  No [ ]  Unknown

1. In the 14 days prior to illness onset, were you traveling away from your home within the United States?

[ ]  Yes [ ]  No [ ]  Unknown

1. *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 |  |  |  |  |
| Trip 5 |  |  |  |  |

## Exposure history

1. 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) \_\_\_\_\_\_\_\_\_\_\_\_

1. 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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.)? | [ ]  Yes [ ]  No [ ]  Unknown |  |
| …have close contact (e.g. caring for, speaking with, or touching) with any ill persons? | [ ]  Yes [ ]  No [ ]  Unknown |  |
| …attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?  | [ ]  Yes [ ]  No [ ]  Unknown |  |
| …use public transportation (bus, train, airplane)? | [ ]  Yes [ ]  No [ ]  Unknown |  |
| …attend or work at a school or daycare? | [ ]  Yes [ ]  No [ ]  Unknown |  |
| …have a household member who attended school or daycare?  | [ ]  Yes [ ]  No [ ]  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)?  | [ ]  Yes [ ]  No [ ]  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? | [ ]  Yes [ ]  No [ ]  UnknownIf yes where did the person travel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. 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:  | [ ]  Y [ ]  N [ ]  Unk If yes, what was your role:[ ]  Physician [ ]  Nurse [ ]  Administration staff [ ]  Housekeeping [ ]  Patient transport [ ] Other, specify\_\_\_\_\_\_\_\_\_\_ | [ ]  Hospital [ ]  Urgent Care [ ]  Doctor’s office/clinic  | [ ]  Dialysis unit/center [ ]  Long Term Care Facility[ ]  Other (specify) |  |
| Volunteer in healthcare setting | [ ]  Y [ ]  N [ ]  Unk | [ ]  Hospital [ ]  Urgent Care [ ]  Doctor’s office/clinic  | [ ]  Dialysis unit/center [ ]  Long Term Care Facility[ ]  Other (specify) |  |
| Have direct patient contact | [ ]  Y [ ]  N [ ]  Unk | [ ]  Hospital [ ]  Urgent Care [ ]  Doctor’s office/clinic  | [ ]  Dialysis unit/center [ ]  Long Term Care Facility[ ]  Other (specify) |  |
| Visit healthcare setting as a patient (not just for this illness) | [ ]  Y [ ]  N [ ]  Unk | [ ]  Hospital [ ]  Urgent Care [ ]  Doctor’s office/clinic  | [ ]  Dialysis unit/center [ ]  Long Term Care Facility[ ]  Other (specify) |  |
| Visit healthcare setting for any reason other than as a patient | [ ]  Y [ ]  N [ ]  Unk | [ ]  Hospital [ ]  Urgent Care [ ]  Doctor’s office/clinic  | [ ]  Dialysis unit/center [ ]  Long Term Care Facility[ ]  Other (specify) |  |
| Contact with a known COVID-19 case-patient in a healthcare setting | [ ]  Y [ ]  N [ ]  Unk If yes, as a[ ]  Patient[ ]  Visitor[ ]  HCW | [ ]  Hospital [ ]  Urgent Care [ ]  Doctor’s office/clinic  | [ ]  Dialysis unit/center [ ]  Long Term Care Facility[ ]  Other (specify) |  |

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *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) |
| --- | --- | --- | --- | --- | --- |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |
| [ ]  A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  Unk |  |

## Symptoms

1. What was the onset date of your first symptom (MM/DD/YYYY): \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ [ ] Unknown
2. 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

1. What was the first symptom you experienced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 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

1. 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) | [ ] Yes [ ] No [ ] Unknown |  |  |
|  Highest temp\_\_\_\_\_\_\_\_ °F |  |  |  |
| Subjective fever (felt feverish) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Chills  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Sweats | [ ] Yes [ ] No [ ] Unknown |  |  |
| Dehydration | [ ] Yes [ ] No [ ] Unknown |  |  |
| Cough (new onset or worsening of chronic cough) | [ ] Yes [ ] No [ ] Unknown |  |  |
|  Dry  | [ ] Yes [ ] No [ ] Unknown |  |  |
|  Productive | [ ] Yes [ ] No [ ] Unknown |  |  |
|  Bloody sputum (hemoptysis) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Sore throat | [ ] Yes [ ] No [ ] Unknown |  |  |
| Wheezing | [ ] Yes [ ] No [ ] Unknown |  |  |
| Shortness of breath (dyspnea) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Runny nose (rhinorrhea) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Stuffy nose (nasal congestion) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Loss of smell (Anosmia) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Loss of taste (Ageusia) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Swollen Lymph Nodes (Lymphadenopathy) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Eye redness (conjunctivitis)  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Rash | [ ] Yes [ ] No [ ] Unknown |  |  |
| Abdominal pain  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Vomiting | [ ] Yes [ ] No [ ] Unknown |  |  |
| Nausea | [ ] Yes [ ] No [ ] Unknown |  |  |
| Loss of appetite (anorexia) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Diarrhea (>3 loose stools/day) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Chest Pain | [ ] Yes [ ] No [ ] Unknown |  |  |
| Muscle aches (myalgia) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Joint Pain (Arthralgia) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Headache | [ ] Yes [ ] No [ ] Unknown |  |  |
| Fatigue  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Seizures | [ ] Yes [ ] No [ ] Unknown |  |  |
| Altered Mental Status (confusion) | [ ] Yes [ ] No [ ] Unknown |  |  |
| Other, specify:  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Other, specify:  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Other, specify:  | [ ] Yes [ ] No [ ] Unknown |  |  |
| Other, specify:  | [ ] Yes [ ] No [ ] Unknown |  |  |

## Past medical history

1. Do you have any pre-existing medical conditions? [ ]  Yes [ ]  No [ ]  Unknown

|  |  |  |  |
| --- | --- | --- | --- |
| **Chronic Lung Disease: Do you have any lung or breathing problems?**  | [ ] Yes | [ ] No | [ ] Unknown |
| Asthma/reactive airway disease  | [ ] Yes | [ ] No | [ ] Unknown |
| Emphysema/Chronic Obstructive Pulmonary Disease (COPD)/Chronic Bronchitis | [ ] Yes | [ ] No | [ ] Unknown |
| Interstitial lung disease | [ ] Yes | [ ] No | [ ] Unknown |
| Pulmonary fibrosis | [ ] Yes | [ ] No | [ ] Unknown |
| Restrictive lung disease | [ ] Yes | [ ] No | [ ] Unknown |
| Sarcoidosis | [ ] Yes | [ ] No | [ ] Unknown |
| Cystic Fibrosis | [ ] Yes | [ ] No | [ ] Unknown |
| Chronic hypoxemic respiratory failure with O2 requirement (Do you use oxygen at home?) | [ ] Yes | [ ] No | [ ] Unknown |
| Obstructive sleep apnea (OSA) | [ ] Yes | [ ] No | [ ] Unknown |
| Other chronic lung disease | [ ] Yes | [ ] No | [ ] Unknown |
|  If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Active tuberculosis | [ ] Yes | [ ] No | [ ] Unknown |
| **Cardiovascular (CV) disease: Do you have any heart or blood vessel problems?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  Hypertension (high blood pressure) | [ ] Yes | [ ] No | [ ] Unknown |
|  Coronary artery disease (heart attack) | [ ] Yes | [ ] No | [ ] Unknown |
|  Heart failure/Congestive heart failure  | [ ] Yes | [ ] No | [ ] Unknown |
|  Cerebrovascular accident/Stroke  | [ ] Yes | [ ] No | [ ] Unknown |
|  Congenital heart disease (childhood heart problem) | [ ] Yes | [ ] No | [ ] Unknown |
|  Valvular Heart Disease (abnormal heart valve[s] – e.g., aortic stenosis, mitral regurgitation) | [ ] Yes | [ ] No | [ ] Unknown |
|  Arrhythmia (abnormal/irregular heartbeat or rhythm) | [ ] Yes | [ ] No | [ ] Unknown |
|  Other CV disease (e.g. peripheral artery disease, aortic aneurysm, cardiomyopathy, or other heart or vessel diseases specified by the patient) | [ ] Yes | [ ] No | [ ] Unknown |
|  If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Endocrine disorder: Do you have any hormone problems, like diabetes?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  Diabetes Mellitus (DM) | [ ] Yes | [ ] No | [ ] Unknown |
|  If yes, specify DM Type 1 or 2 | [ ] Yes | [ ] No | [ ] Unknown |
|  If yes, what level was your last HgA1c? (Hemoglobin A1c or “A1c”)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (MM/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Unknown |
|  Pre-diabetes | [ ] Yes | [ ] No | [ ] Unknown |
|  If yes, what level was your last HgA1c? (Hemoglobin A1c or “A1c”)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (MM/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Unknown |
|  Other endocrine (hormone) disorder (e.g. pituitary problems, hyperthyroidism, hypothyroidism, Addison’s disease, Cushing’s syndrome | [ ] Yes | [ ] No | [ ] Unknown |
|  If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Renal disease: do you have any kidney problems?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  Chronic kidney disease/insufficiency | [ ] Yes | [ ] No | [ ] Unknown |
|  End-stage renal disease | [ ] Yes | [ ] No | [ ] Unknown |
|  Dialysis | [ ] Yes | [ ] No | [ ] Unknown |
|  If yes, specify type: hemodialysis (HD) or peritoneal | [ ] HD | [ ] Peritoneal | [ ] Unknown |
|  Other | [ ] Yes | [ ] No | [ ] Unknown |
|  If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Liver disease: do you have any liver problems?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  Alcoholic hepatitis | [ ] Yes | [ ] No | [ ] Unknown |
|  Chronic liver disease | [ ] Yes | [ ] No | [ ] Unknown |
|  Cirrhosis/End stage liver disease | [ ] Yes | [ ] No | [ ] Unknown |
|  Hepatitis B, chronic  | [ ] Yes | [ ] No | [ ] Unknown |
|  Hepatitis C, chronic  | [ ] Yes | [ ] No | [ ] Unknown |
|  Non-alcoholic fatty liver disease (NAFLD)/NASH | [ ] Yes | [ ] No | [ ] Unknown |
|  Other | [ ] Yes | [ ] No | [ ] Unknown |
|  If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Autoimmune disorders: do you have any autoimmune diseases? These include diseases such as…(*read below conditions)*?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  Rheumatoid arthritis | [ ] Yes | [ ] No | [ ] Unknown |
|  Systemic lupus | [ ] Yes | [ ] No | [ ] Unknown |
|  Other  | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hematologic disorders: do you have any blood problems?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  Anemia | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Sickle cell disease | [ ] Yes | [ ] No | [ ] Unknown |
|  Sickle cell trait | [ ] Yes | [ ] No | [ ] Unknown |
|  Bleeding or clotting disorders | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Other hematologic (blood) disorders | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Immunocompromised Condition: do you have any conditions or diseases that make you more prone to infections?**  | [ ] Yes | [ ] No | [ ] Unknown |
|  HIV infection  | [ ] Yes | [ ] No | [ ] Unknown |
|  If yes, what was your last CD4 Count? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (MM/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Unknown |
|  AIDS or CD4 count <200 | [ ] Yes | [ ] No | [ ] Unknown |
|  Solid organ transplant | [ ] Yes | [ ] No | [ ] Unknown |
|  Stem cell transplant (e.g., bone marrow transplant) | [ ] Yes | [ ] No | [ ] Unknown |
|  Leukemia | [ ] Yes | [ ] No | [ ] Unknown |
|  Lymphoma | [ ] Yes | [ ] No | [ ] Unknown |
|  Multiple myeloma | [ ] Yes | [ ] No | [ ] Unknown |
|  Splenectomy/asplenia | [ ] Yes | [ ] No | [ ] Unknown |
|  Other:  | [ ] Yes | [ ] No | [ ] Unknown |
|  If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Cancer: have you had, or do you have, cancer?**  | [ ] Yes | [ ] No*(skip to next section)* | [ ] Unknown*(skip to next section)* |
|   If yes, what type of cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   What year did were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |
|  Did your cancer treatment include any of the following? *(If yes, specify what years you received treatment)* |
|  IV Chemotherapy | [ ] Yes | [ ] No | [ ] Unknown |  Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Oral chemotherapy (pills) | [ ] Yes | [ ] No | [ ] Unknown |  Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Radiation | [ ] Yes | [ ] No | [ ] Unknown |  Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Yes | [ ] No | [ ] Unknown |  Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Neurologic/neurodevelopmental disorder: do you have any diseases of the brain, spinal cord, or nerves?**  | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Psychiatric Diagnosis: do you have any mental health problems? (e.g. depression, bipolar disorder, anxiety disorder, schizophrenia)** | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other chronic diseases:**  | [ ] Yes | [ ] No | [ ] Unknown |
|   If Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Current height: \_\_\_\_\_\_\_\_\_ (inches) OR \_\_\_\_\_\_\_\_\_\_ (cm)
2. Current weight: \_\_\_\_\_\_\_\_\_ (pounds) OR \_\_\_\_\_\_\_\_\_\_ (kg)
3. 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

1. Are you bed-ridden? [ ]  Yes [ ]  No
2. If female, are you currently pregnant? [ ]  Yes Weeks pregnant at illness onset\_\_\_\_\_\_\_\_\_ [ ]  No [ ]  Unknown
3. If female, are you postpartum ($\leq $6 weeks postpartum)? [ ]  Yes [ ]  No [ ]  Unknown
4. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If female, are you breastfeeding? [ ]  Yes [ ]  No [ ]  Unknown
2. If child, is he/she being breastfed? [ ]  Yes [ ]  No [ ]  Unknown
3. 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

1. **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?** |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown  |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown  |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown  |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown  |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown  |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown  |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

1. **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** |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

1. *If Chloroquine was listed as a medication taken*: What dose of Chloroquine did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ unit: \_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown

## Social history

1. Do you currently smoke cigarettes? [ ]  Yes [ ]  No [ ]  Unknown
If yes, how many packs of cigarettes per day? \_\_\_\_\_\_ For how many years? \_\_\_\_\_
2. 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)
3. Do you currently use e-cigarettes/vape-pen? [ ]  Yes [ ]  No [ ]  Unknown
4. 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**.

1. 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? |
| [ ]  Marijuana/THC |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |
|  If yes, do you inhale or consume THC/marijuana? *(check all that apply)*  | [ ]  Inhale [ ]  Consume |
| [ ]  Cocaine |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |
| [ ]  Heroin |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |
| [ ]  Methamphetamine (”Meth”) |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |
| [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |
| [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |
| [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | [ ]  No [ ]  Yes, more than usual [ ]  Yes, the same amount[ ]  Yes, but less than usual [ ]  Unknown |

## Course of Illness

1. Did you miss work or school for this illness? [ ]  Yes [ ]  No [ ]  Unknown

If yes, how many days during illness? \_\_\_\_\_\_\_\_\_\_

1. Did you receive any medical care for the illness? [ ]  Yes [ ]  No [ ]  Unknown
2. 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]

|  |  |  |
| --- | --- | --- |
| [ ]  Doctor’s office | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
|  Name of healthcare facility 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Facility 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Emergency room  | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
|  Name of healthcare facility 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Facility 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Retail store/pharmacy  | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
| [ ]  Health department | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
| [ ]  Urgent care | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
|  Name of healthcare facility 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Facility 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Telephone triage line | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
|  Name of healthcare facility 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Facility 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Telemedicine | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
|  Name of healthcare facility 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Facility 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Other \_\_\_\_\_\_\_\_\_\_ | Date 1: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)  | Date 2: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) |
|  Name of healthcare facility 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Facility 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Unknown  |  |  |

1. Did you have any imaging such as an X-ray or CT for this illness? [ ]  Yes [ ]  No [ ]  Unknown
2. Did you have any blood tests done for this illness? [ ]  Yes [ ]  No [ ]  Unknown
3. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **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^** |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  after^ | Indication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  PO [ ]  Injection [ ]  Topical [ ]  Inhaled [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  QD [ ]  BID [ ]  TID [ ]  QOD[ ]  Unknown [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes [ ]  No [ ]  Unknown | \_\_\_\_\_\_\_\_\_\_days |
| [ ]  before onset\* [ ]  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.**