**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

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  Unknown  If 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 symptomaticSymptoms 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 (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.**