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

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

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

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

COVID-19 Case Interview Form

Record ID: CO_____

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____

Telephone _____ Email _____

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

Data sources used for this form?

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

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

Case-patient demographic information

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

Travel history

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

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

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Trip 5				

Exposure history

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

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

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

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

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

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

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

Exposure	**Answer**	**Date Range**
…have any household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (e.g. cough, sore throat etc.)?	☐ 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:_____	

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

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

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	☐ Housekeeping ☐ Patient transport ☐ 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)	

19. Do you reside in a facility or group setting (e.g. long-term care facility/nursing home, boarding school, college dormitory, etc.)?
☐ Yes ☐ No ☐ Unknown

If yes, what type of group setting do you live in? ☐ Military base ☐ Shelter ☐ Nursing home/long-term healthcare facility
☐ Assisted Living Facility ☐ Hospice ☐ School dormitory ☐ Homeless ☐ Detention/correctional facility
☐ Foster care group setting ☐ Other: _____

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

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

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HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the ***14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness***?	Date of illness onset of household member (MM/DD/YYYY)
☐ 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

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

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

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

Symptom	**Symptom Present?**	**Date of Onset (MM/DD/YY)**	**Duration (no. of days)**
Fever >100.4F (38C)	☐ 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		

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Symptom	Symptom Present?	Date of Onset (MM/DD/YY)	Duration (no. of days)
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

26. 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

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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: _____			

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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,	☐ Yes	☐ No	☐ Unknown

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anxiety disorder, schizophrenia)			
If Yes, specify: _____			
Other chronic diseases:	☐ Yes	☐ No	☐ Unknown
If Yes, specify: _____			

27. Current height: _____ (inches) OR _____ (cm)
28. Current weight: _____ (pounds) OR _____ (kg)
29. Do you use or depend on any of the following?
    - Feeding tube ☐ Yes ☐ No ☐ Unknown
    - Tracheostomy ☐ Yes ☐ No ☐ Unknown
    - Wheelchair ☐ Yes ☐ No ☐ Unknown
    - Walker ☐ Yes ☐ No ☐ Unknown
30. Are you bed-ridden? ☐ Yes ☐ No

31. If female, are you currently pregnant? ☐ Yes Weeks pregnant at illness onset_____ ☐ No ☐ Unknown
32. If female, are you postpartum (≤6 weeks postpartum)? ☐ Yes ☐ No ☐ Unknown
33. If currently pregnant or postpartum, have you had or did you have any complications during this pregnancy?
    ☐ None ☐ Gestational diabetes ☐ Pre-eclampsia ☐ Pregnancy-induced hypertension (PIH) ☐ Intrauterine growth restriction (IUGR)
    ☐ Other, specify: _____
34. If female, are you breastfeeding? ☐ Yes ☐ No ☐ Unknown
35. If child, is he/she being breastfed? ☐ Yes ☐ No ☐ Unknown

36. Do you have health insurance? ☐ Yes ☐ No ☐ Unknown
    If yes, what kind of health insurance do you have? ☐ Private ☐ Medicare ☐ Medicaid ☐ Indian Health Service (IHS)
    ☐ Military (Tricare) ☐ Incarcerated ☐ Unknown/Did not want to answer

Medication history

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

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

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

Medication Name	Route	Frequency	Continued to take during Illness?
	☐ PO ☐ Injection ☐ Topical ☐ Inhaled	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown	☐ Yes ☐ No ☐ Unknown

	☐ Other ______________	☐ Other ______________	
	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: ______________		

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

38. **During your COVID-19 illness**, did you take any medications <u>other than the medications we covered in the previous section</u>? This includes prescriptions, inhalers, over the counter medications, vitamins, supplements, and herbs. <u>**If you were hospitalized for this illness**</u>, 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	☐ QD ☐ BID ☐ TID ☐ QOD ☐ Unknown	______________ days

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	☐ Other ____________	☐ Other ______________	
	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: ______________________________		

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

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

Social history

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

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

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

What substance do you use? *(check all that apply)*	Around how many times in the **month prior to becoming sick** did you use?	Did you use while sick with COVID-19?
☐ 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

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☐ 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

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

☐ 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		

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

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COVID-19 Case Interview Form

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

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☐ 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.