Million Veteran Program (MVP)
COVID-19 Survey

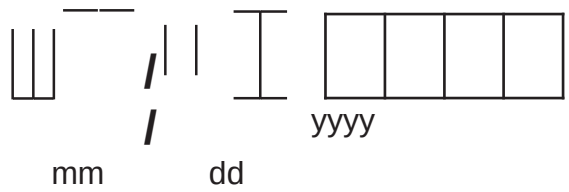
OMB No. 2900-_____
Estimated Burden: 25 minutes
Expiration Date: _____

The Paperwork Reduction Act of 1995: This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 25 minutes. This includes the time it will take to follow instructions, gather the necessary facts, and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services, as well as customer expectations and desires. This survey data will be analyzed in conjunction with biospecimens collected as part of the MVP and will assist with identification of potential biomarkers and allow researchers to analyze the incidence and outcomes of COVID-19 using genomic data. Participation in this survey is voluntary, and failure to respond will have no impact on benefits to which you may be entitled.

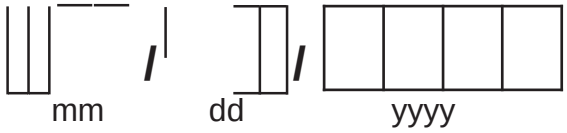
Privacy Act Statement: Information on this form is collected in accordance with Information on this form is collected in accordance with the Privacy Act of 1974 (5 U.S.C. § 552a), Code of Federal Regulations Title 38, Part 16, and the MVP research protocol approved by the VA Central Institutional Review Board.
Information gathered will be kept private to the extent provided by law. The data we collect will be aggregated, and disclosure of information will involve the release of statistical data and other non-identifying data for improving the quality of service delivery. No information will be attributable to you as an individual.

Section A: Demographics

1. What is today's date?



2. What is your date of birth?



3. What is your gender?

7. What is your current marital status?

- ☐ Married
- ☐ Civil commitment
- ☐ Cohabitating
- ☐ Divorced
- ☐ Widowed
- ☐ Never married
- ☐ Separated

8. Including yourself, how many people currently live in your household?

1 2 3 4 5 6 7 8 9+

☐ Male
☐ Female
☐ Prefer not to answer

4. Are you Spanish, Hispanic, or Latino?

☐ No, not Spanish, Hispanic, Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish, Hispanic, Latino

***5.* What is your race?** *(Mark all that apply)*

☐ White
☐ Black / African - American
☐ American Indian / Alaska Native
☐ Chinese
☐ Japanese
☐ Asian Indian
☐ Other Asian
☐ Filipino
☐ Pacific Islander
☐ Other

6. What is your highest degree or level of school you have completed?

☐ Less than high school
☐ High school diploma / GED
☐ Some college credit, but no degree
☐ Associate's degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, BS)
☐ Master's degree (e.g., MA, MS, MBA)
☐ Professional or Doctorate degree

11. What is your weight:

pounds

9. Which income category represents the total income of your household from all sources (before taxes and deductions) during the last 12 months?

☐ Less than $10,000
☐ $10,000 - $19,999
☐ $20,000 - $29,999
☐ $30,000 - $39,999
☐ $40,000 - $49,999
☐ $50,000 - $59,999
☐ $60,000 - $74,999
☐ $75,000 - $99,999
☐ $100,000 - $149,999
☐ $150,000 or more
☐ Prefer not to answer

10. What is your height:

☐ feet ☐☐ inches

☐☐☐

12. In which branch of the service did you serve? *(Mark all that apply)*

- ☐ Army
- ☐ Navy
- ☐ Air Force
- ☐ Coast Guard
- ☐ Marine Corps
- ☐ National Guard
- ☐ Merchant Marines
- ☐ NOAA
- ☐ Public Health Service
- ☐ None *(Skip to Qu. 15)*

13. Please indicate whether your service was:

- ☐ Active Duty
- ☐ Reserves Only
- ☐ Not Applicable (Not in the military)

14. When did you serve? *(Mark all that apply)*

- ☐ September 2001 or later
- ☐ August 1990 to August 2001 (includes Gulf War)
- ☐ May 1975 to July 1990
- ☐ August 1964 to April 1975 (Vietnam era)
- ☐ February 1955 to July 1964
- ☐ July 1950 to January 1955 (Korean War)
- ☐ January 1947 to June 1950
- ☐ December 1941 to December 1946 (WWII)
- ☐ November 1941 or earlier

15. How often do you have a drink containing alcohol

- ☐ Never *(Skip to Qu. 18)*
- ☐ 1 – 3 days per month
- ☐ 1 day per week
- ☐ 2 – 3 days per week
- ☐ 4 – 5 days per week
- ☐ 6 or more days per week

16. How many drinks containing alcohol do you have on a typical day when you are drinking?

- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

17. How often do you have six or more drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ 2 – 3 times per week
- ☐ 4 or more times per week

18. In your lifetime have you smoked a total of at least 100 cigarettes, cigars, or pipes?

- ☐ Yes
- ☐ No *(Skip to Qu. 21)*

Have you ever smoked daily or almost every day for at least one year?

- ☐ Yes
- ☐ No

20. Do you smoke now?

- ☐ Yes, daily
- ☐ Yes, occasionally
- ☐ Not at all

The following questions concern electronic vaping products for nicotine use. Do not include marijuana use.

21. Have you ever used an e-cigarette or other electronic vaping product, even just one time, in your entire life?

- ☐ Yes
- ☐ No *(Skip to Qu. 23)*
- ☐ Prefer not to answer *(Skip to Qu. 23)*
- ☐ Don't know *(Skip to Qu. 23)*

22. Do you NOW use e-cigarettes or other electronic vaping products every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all
- ☐ Prefer not to answer
- ☐ Don't know

Section B: COVID-19 Exposure/Household Contact

23. Have you been in close contact with anyone with COVID-19 like symptoms?

- ☐ Yes, I was in contact with a person with COVID-19 who was confirmed positive by a test
- ☐ Yes, I was in contact with a person with COVID-19 symptoms, but was not confirmed by a test
- ☐ No, not to my knowledge

***24.* Has anyone in your household had COVID-19?** *Please do not include yourself.*

- ☐ Yes
- ☐ No

Please indicate the number of people.

People ____

25. Are you a healthcare worker helping to manage patients with COVID-19?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

Section C: COVID-19 Symptoms/Diagnosis

26. Have you experienced any of the following symptoms more than normal since January 2020? Please check "Yes" or "No" next to each symptom and provide the date the symptoms began.

If yes, please indicate the date and number of days you experienced any of these symptoms.	No	Yes	Date Symptoms Began [MM/DD/YYYY]	Number of Days You Experienced Symptom
a. Coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours				
b. Shortness of breath				
c. Unusual chest pain or tightness in your chest				
d. Fatigue (struggling to get out of bed)				
e. Feeling of heaviness in arms or legs				
f. Headache				
g. Loss of sense of smell or taste				
h. Sore throat				
i. Diarrhea, nausea and/or vomiting				
j. Fever/chills (temp>100.4 Fahrenheit)				

27. Did you seek medical attention for these symptoms? *If yes, please include the date that you received medical care.*

☒ Yes

☐ No *(Skip to Qu. 41)*

a. If yes, please indicate where you received care and the date care was received:

☐ VA facility (Date) [MM/DD/YYYY]

☐ Non-VA facility (Date) [MM/DD/YYYY]

b. If yes, how long after your symptoms started did you seek care?

☐ Less than 2 days

☐ 2 – 7 days

☐ Greater than 1 week

28. Did doctors use a laboratory test to check that you didn't have influenza (Flu)?

☐ Yes

☐ No

☐ Don't know

29. Have you been diagnosed with COVID-19? *Please indicate if you were diagnosed at a VA-facility or Non-VA facility.*

☐ Yes, confirmed by a positive laboratory test _____VA-Facility _____Non-VA Facility

☐ Yes, suspected by a doctor but not confirmed by a test *(Skip to Qu. 41)*

☐ No *(Skip to Qu. 41)*

30. Please indicate the type of laboratory test you received to diagnose COVID-19 and date of test.

☐ Yes, by nasal swab (PCR)
Date _____ [MM/DD/YYYY]

☐ Yes, by blood test (antibody)
Date _____[MM/DD/YYYY]

☐ Yes, by self-administered at-home testing Date

☐ Yes, by another test
Date _____[MM/DD/YYYY]

☐ Don't know the type of test
Date _____[MM/DD/YYYY]

31. Is there a suspected source of your COVID-19?

☐ Travel related

☐ Spouse

☐ Child

☐ Extended family member

☐ Coworker or other work contact

☐ Friend or other social contact

☐ Don't know

☐ Prefer not to answer

Section D: COVID-19 Medical Treatment and Hospitalization

32. Did you receive medical treatment for COVID-19?

☐ Yes

____ VA Facility ____Non-VA Facility

☐ No

33. Were you hospitalized for COVID-19?

☐ Yes

____ VA Facility ____Non-VA Facility

☐ No *(Skip to Qu. 38)*

34. When were you admitted to the hospital for treatment of COVID-19?

__ / __ / ____

mm dd yyyy

35. What date were you discharged from the hospital after treatment of COVID-19?

__ / __ / ____

mm dd yyyy

36. Did you require a breathing tube through the mouth for respiratory support while in the hospital (intubation / mechanical ventilation / respirator)?

☐ Yes

☐ No

37. Were you hospitalized in an Intensive Care Unit (ICU) for treatment of COVID-19?

☐ Yes

☐ No

38. Do you know if doctors used any of the following medications to treat your illness while you were sick with COVID-19? *(Mark all that apply)*

Medication	**Did doctors use this medication?**	**If yes, indicate date**
Tamiflu (oseltamivir) or Xofluza (baloxavir marboxil)	☐ Yes ☑ No	MM/DD/YYYY
Chloroquine or Hydroxychloroquine	☐ Yes ☐ No	MM/DD/YYYY
Azithromycin	☐ Yes ☐ No	MM/DD/YYYY
Remdesivir	☐ Yes ☐ No	MM/DD/YYYY
Dexamethasone	☐ Yes ☐ No	MM/DD/YYYY
Convalescent Plasma	☐ Yes ☐ No	MM/DD/YYYY
Experimental medications/treatments	☐ Yes ☐ No	MM/DD/YYYY
Other treatment	☐ Yes ☐ No	MM/DD/YYYY
Don't know	☐ Yes ☐ No	MM/DD/YYYY

39. Did you receive respiratory support at home to treat your COVID-19, such as oxygen therapy by nasal prong or facemask or CPAP machine?

☐ Yes

☐ No *(Skip to Qu. 41)*

40. If yes, for how long did you need respiratory support at home? *Please enter the duration of your respiratory support in days*

Section E: COVID-19 Impact Behavior/Well-Being

The next questions ask about your behaviors and well-being since the COVID-19 pandemic and the impact it has had on you. For each of the statements below, please select the best choice that describes your response. (Select only one response for each question or statement).

41. Which of the following have you done since the COVID-19 pandemic?

	Never	Sometimes	Most of the Time	Always
Used a face mask or other face covering while in public	☐	☐	☐	☐
Used gloves while in public	☐	☐	☐	☐
Washed your hands with soap or used hand sanitizer several times a day	☐	☐	☐	☐
Cleaned high touch surfaces like door handles, counters, faucets, and remote controls	☐	☐	☐	☐
Practiced social distancing (avoiding contact with anyone outside of the home)	☐	☐	☐	☐
Avoided contact with people who could be high-risk	☐	☐	☐	☐
Avoided eating at restaurants	☐	☐	☐	☐
Avoided public spaces, gatherings, or crowds	☐	☐	☐	☐
Avoided gatherings of more than 50	☐	☐	☐	☐

42. Since the COVID-19 pandemic started, have any of the following aspects of your life changed?

		Decreased	Stayed the Same	Increased	Not Applicable
a.	**Amount you sleep**	☐	☐	☐	☐
b.	**Amount of physical activity you do**	☐	☐	☐	☐
c.	**Amount you smoke/vape**	☐	☐	☐	☐
d.	**Amount of alcohol you drink**	☐	☐	☐	☐
e.	**Number of hours you work in usual workplace**	☐	☐	☐	☐
f.	**Number of hours you work at home**	☐	☐	☐	☐
g.	**Time spent talking to family/friends**	☐	☐	☐	☐
h.	**Time spent talking to work colleagues**	☐	☐	☐	☐
i.	**Practicing relaxation / mindfulness / meditation**	☐	☐	☐	☐
j.	**Time watching TV/streaming services**	☐	☐	☐	☐
k.	**Time spent reading or listening to the news**	☐	☐	☐	☐
l.	**Time spent on social media**	☐	☐	☐	☐
m.	**Time spent playing video games**	☐	☐	☐	☐
n.	**Time spent doing hobbies/things you enjoy**	☐	☐	☐	☐
o.	**Amount you eat**	☐	☐	☐	☐
p.	**Amount of money you've spent**	☐	☐	☐	☐

43. Over the past 2 weeks, have you been bothered by any of these problems?

		Not at all	Several days	More days than not	Nearly every day
a.	**Feeling nervous, anxious, or on edge**	☐	☐	☐	☐
b.	**Not being able to stop or control worrying**	☐	☐	☐	☐
c.	**Feeling down, depressed, or hopeless**	☐	☐	☐	☐
d.	**Little interest or pleasure in doing things**	☐	☐	☐	☐

44. Since the COVID-19 pandemic, for each of the statements below please select the best choice that describes how you feel. *Select only one response for each question or statement***.**

		Never	Rarely	Sometimes	Usually	Always	Don't know or N/A
Social Isolation							
a.	**I feel left out…**	☐	☐	☐	☐	☐	☐
b.	**I feel that people barely know me…**	☐	☐	☐	☐	☐	☐
c.	**I feel isolated from others…**	☐	☐	☐	☐	☐	☐
d.	**I feel that people are around me, but not with me…**	☐	☐	☐	☐	☐	☐

45. Since the COVID-19 pandemic, for each of the statements below please select the best choice that describes how you feel. *Select only one response for each question or statement***.**

		Never	Rarely	Sometimes	Usually	Always	Don't know or N/A
Emotional Support							
a.	**I have someone who will listen to me when I need to talk.**	☐	☐	☐	☐	☐	☐
b.	**I have someone to confide in or talk to about myself or my problems.**	☐	☐	☐	☐	☐	☐
c.	**I have someone who makes me feel appreciated.**	☐	☐	☐	☐	☐	☐
d.	**I have someone to talk with when I have a bad day.**	☐	☐	☐	☐	☐	☐

46. Since the COVID-19 pandemic, for each of the items below please select the best choice describing the degree of impact. *Select only one response for each question or statement.*

		No Loss	Minimal Loss	Noticeable Loss	Extreme Loss	Don't Know or N/A
a.	**Adequate food**	☐	☐	☐	☐	☐
b.	**Your residence / home you live in**	☐	☐	☐	☐	☐
c.	**Things you need for your children or members of your household**	☐	☐	☐	☐	☐
d.	**Money for extras**	☐	☐	☐	☐	☐
e.	**Savings or emergency money**	☐	☐	☐	☐	☐
f.	**Adequate income**	☐	☐	☐	☐	☐
g.	**Financial credit**	☐	☐	☐	☐	☐
h.	**Your retirement security**	☐	☐	☐	☐	☐
i.	**Free time**	☐	☐	☐	☐	☐
j.	**Time for enough sleep**	☐	☐	☐	☐	☐
k.	**Feeling valuable to other people**	☐	☐	☐	☐	☐
l.	**A feeling of intimacy with one or more family members**	☐	☐	☐	☐	☐
m.	**The feeling that you're accomplishing the goals in your life**	☐	☐	☐	☐	☐
n.	**Time with your loved ones**	☐	☐	☐	☐	☐
o.	**The sense of a daily routine**	☐	☐	☐	☐	☐
p.	**Health of a family member / friend**	☐	☐	☐	☐	☐
q.	**Stable employment**	☐	☐	☐	☐	☐
r.	**Ability to organize tasks**	☐	☐	☐	☐	☐
s.	**Time needed to do your work**	☐	☐	☐	☐	☐
t.	**Understanding from your boss**	☐	☐	☐	☐	☐
u.	**Support from your co-workers**	☐	☐	☐	☐	☐
v.	**The chance to get more training or education**	☐	☐	☐	☐	☐

	Continued	No Loss	Minimal Loss	Noticeable Loss	Extreme Loss	Don't Know or N/A
w.	**Feeling of being independent**	☐	☐	☐	☐	☐
x.	**Companionship with others**	☐	☐	☐	☐	☐
y.	**Feeling that your life has meaning or purpose**	☐	☐	☐	☐	☐
z.	**Involvement with your church**	☐	☐	☐	☐	☐
aa.	**Help with tasks at home**	☐	☐	☐	☐	☐
bb.	**Loyalty of friends**	☐	☐	☐	☐	☐
cc.	**Help with childcare**	☐	☐	☐	☐	☐
dd.	**Involvement in organizations or clubs**	☐	☐	☐	☐	☐

Section F: Medical Conditions/Comorbidity

47. We'd like to ask about your general health. Please tell us if you have ever been diagnosed with the following conditions. Check the appropriate box and indicate the year of diagnosis and whether you currently take any medication(s) ("TAKE MEDS") for that condition. *(Mark all that apply)*

48.

Circulatory System Problems	YES	YEAR DIAGNOSED	TAKE MEDS
High blood pressure (Hypertension)	☐		☐
Stroke	☐		☐
Transient ischemic attack (TIA)	☐		☐
Heart attack	☐		☐
Coronary artery / Coronary heart disease (includes angina)	☐		☐
Peripheral vascular disease	☐		☐
High cholesterol			
Pulmonary embolism or deep vein thrombosis (DVT)	☐		☐
Congestive heart failure			
Other circulatory system problem	☐		☐

Mental Health Disorders	YES	YEAR DIAGNOSED	TAKE MEDS
Anxiety reaction / Panic disorder	☐		☐
Attention deficit hyper-activity disorder (ADHD)	☐		☐
Bipolar disorder	☐		☐
Post traumatic stress disorder (PTSD)	☐		☐
Depression	☐		☐
Eating disorder	☐		☐
Personality disorder			
Schizophrenia	☐		☐
Social phobia			
Other mental health disorder	☐		☐

	YES	YEAR DIAGNOSED	TAKE MEDS
Osteoarthritis			
Rheumatoid arthritis	☐		☐
Other arthritis			
Gout	☐		☐
Osteoporosis	☐		☐
Other skeletal / muscular problem	☐		☐

	YES	YEAR DIAGNOSED	TAKE MEDS
Cataracts			
Glaucoma	☐		☐
Macular degeneration	☐		☐
Blindness, all causes	☐		☐
Tinnitus or ringing in the ears	☐		☐
Severe hearing loss or partial deafness in one or both ears	☐		☐

Infectious Diseases

	YES	YEAR DIAGNOSED	TAKE MEDS
Tuberculosis	☐		☐
Hepatitis C	☐		☐
HIV / AIDS	☐		☐
Other infectious disease	☐		☐

	YES	YEAR DIAGNOSED	TAKE MEDS
Kidney disease without dialysis	☐		☐
Kidney disease with dialysis	☐		☐
Acute kidney disease with no current dialysis	☐		☐

	YES	YEAR	TAKE
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐

Cancer

	YES	YEAR DIAGNOSED	TAKE MEDS
Breast cancer	☐		☐
Colon cancer / Rectal cancer	☐		☐
Lung cancer	☐		☐
Prostate cancer	☐		☐
Skin cancer	☐		☐
Other cancer	☐		☐

	YES	YEAR DIAGNOSED	TAKE MEDS
Migraine headaches	☐		☐
Other headaches	☐		☐
Memory loss or	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐

	YES	DIAGNOSED	MEDS
Acid reflux / GERD			
Peptic ulcers			
Bowel obstruction			
Colon polyps			
Irritable bowel syndrome (IBS)			
Ulcerative colitis			
Crohn's disease			
Celiac disease / Sprue			
Other digestive system disorder			

	YES	DIAGNOSED	MEDS
impairment			
Dementia (includes Alzheimer's, vascular, etc.)			
Concussion or loss of consciousness			
Traumatic brain injury			
Spinal cord injury or impairment			
Epilepsy / Seizure			
Parkinson's disease			
Amyotrophic lateral sclerosis (Lou Gehrig's disease)			
Multiple sclerosis			
Other nervous system problem			

Other Conditions

YEAR TAKE YES DIAGNOSED MEDS

Asthma

Chronic lung disease (COPD, Emphysema or Bronchitis)

Diabetes / “sugar”

Enlarged prostate (Benign prostatic hyperplasia)

Liver condition (e.g., Cirrhosis)

Skin condition (e.g., Eczema, Psoriasis)

Sleep apnea

Thyroid problems

Gulf War Illness/ Syndrome

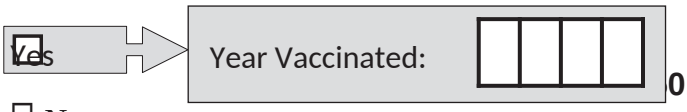
Skin condition (e.g., Eczema, Psoriasis)

Chronic Fatigue Syndrome Fibromyalgia

Other disease / disorder

48. Did you receive the following vaccines while in the military? *If yes, please write in the year of the last vaccine dose.*

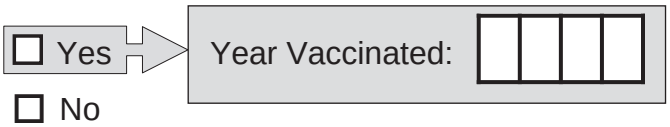
Anthrax



☐ No

☐ Don't Know

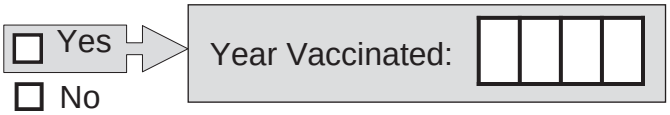
Small Pox



☐ No

☐ Don't Know

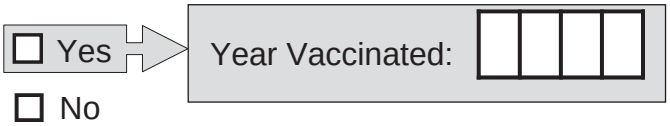
Rabies



☐ No

☐ Don't Know

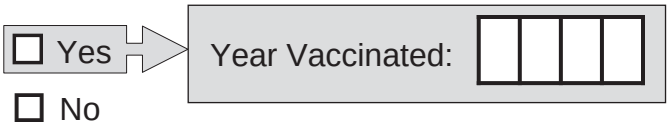
Yellow Fever



☐ No

☐ Don't Know

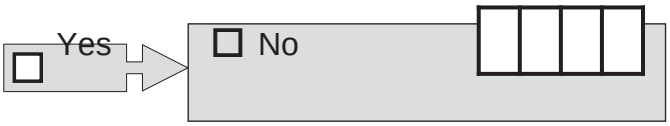
Typhoid



☐ No

☐ Don't Know

Japanese Encephalitis



49. In general, would you say your health is:

☐ Excellent ☐ Fair

☐ Very Good ☐ Poor

☐ Good

50. In the PAST YEAR, have you received health care that was paid for by any of the following insurance types? *(Mark all that apply)*

☐ Private insurance ☐ Veterans Choice Program

☐ TRICARE

☐ Medicare ☐ VA health care

☐ Medicaid ☐ Indian Health

51. In the PAST YEAR, about how much of your health care did you get at a VA facility (e.g., doctor's visits, hospitalizations, urgent care visits, or counseling)?

☐ None ☐ 51 – 75%

☐ 1 – 25% ☐ 76 – 99%

☐ 26 – 50% ☐ 100%

52. In the PAST YEAR, how many times were you a patient in a hospital overnight or longer?

VA Facility

☐ None ☐ 4 - 6 ☐ 10 or more

☐ 1 - 3 ☐ 7 - 9

Non-VA Healthcare Facility

☐ None ☐ 4 - 6 ☐ 10 or more

☐ 1 - 3 ☐ 7 - 9

53. How many <u>prescription</u> medications do you currently receive from:

VA Pharmacy

☐ None
☐ 1 - 3
☐ 4 - 6
☐ 7 - 9
☐ 10 or more

Non-VA Pharmacy

☐ None
☐ 1 - 3
☐ 4 - 6
☐ 7 - 9
☐ 10 or more

54. How many <u>non-prescription</u> medications do you currently receive from:

VA Pharmacy

☐ None
☐ 1 - 3
☐ 4 - 6
☐ 7 - 9
☐ 10 or more

Non-VA Pharmacy

☐ None
☐ 1 - 3
☐ 4 - 6
☐ 7 - 9
☐ 10 or more

55. Did you receive the seasonal flu shot in the last six months?

☐ Yes
____ VA Facility ____Non-VA Facility

☐ No

☐ Don't know

56. In the past, how likely were you to receive your annual flu shot?

☐ Always

☐ Most of the time

☐ Some of the time

☐ Never

Comments concerning the accuracy of the survey burden estimate and suggestions for reducing this burden should be sent to: MVP at AskMVP@va.gov