Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019-Novel Coronavirus (2019-nCoV) Case Report Form

State/local ID: _____ CDC ID:_____ Dash sticker:
Household ID: _____Cluster ID:_____ :_____

Interviewer Information

Date interview completed: / / (MM/DD/YYYY) Date reported to health department: / / (MM/DD/YYYY)
Interviewer Name:_____ State/Local Health Department_____
Who is providing information for this form?
☐Case-patient
☐Other, specify name: _____ Relationship to case patient: _____
Case-patient primary language: _____ Was this form administered via a translator? □ Yes □ No

Case-Patient Information

Last Name: _____ First Name: _____
Current Address: _____ City: _____ State: _____ Zip: _____
Phone No. 1: _____ Other point of contact name:_____ Other point of contact Phone: Relationship to case patient: _____
Phone No. 2:_____
Date reported to health department: / / (MM/DD/YYYY)
At the time of this report, is this patient a 2019-nCoV laboratory-confirmed case? ☐ Yes ☐No

Demographic information

1. Date of birth:_____/_____/_____(MM/DD/YYYY)
2. Age: _____ ☐ years ☐ months
3. Current residence: Country: _____ State:_____County_____City_____
4. Living situation at time of illness: ☐ Private residence ☐ Military base ☐ Shelter ☐ Nursing home/long-term healthcare facility ☐ School dormitory ☐ Homeless ☐ Detention facility ☐ Other: _____
5. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
6. Race (Select all that apply): ☐White ☐Asian ☐American Indian/Alaska Native ☐Black or African American ☐Native Hawaiian/Other Pacific Islander
7. Sex: ☐ Male ☐Female
8. Is the patient a healthcare worker? ☐ Yes ☐ No ☐ Unknown
9. Occupation _____

Clinical Presentation and Course

10. Date of first symptom onset ___/___/_____(MM/DD/YYYY)
11. Does the patient still have symptoms?
☐Yes ☐No ☐ Unknown
12. When did the patient feel back to normal?_____/_____/_____(MM/DD/YYYY)
13. During this illness, did the patient experience any of the following?

Symptom	Symptom Present?	Date of Onset (MM/DD/YY)	Duration (no. of days)
Fever >100.4F (38C)	☐Yes ☐No ☐Unk		
Highest temp_____ °F			
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk		
Chills	☐Yes ☐No ☐Unk		
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk		
Dry	☐Yes ☐No ☐Unk		
Productive	☐Yes ☐No ☐Unk		
Bloody sputum (hemoptysis)	☐Yes ☐No ☐Unk		
Sore throat	☐Yes ☐No ☐Unk		
Wheezing	☐Yes ☐No ☐Unk		
Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk		
Swollen lymph nodes (lymphadenopathy)	☐Yes ☐No ☐Unk		
Apnea	☐Yes ☐No ☐Unk		
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk		
Eye redness (conjunctivitis)	☐Yes ☐No ☐Unk		
Ear pain	☐Yes ☐No ☐Unk		
Rash	☐Yes ☐No ☐Unk		
Abdominal pain	☐Yes ☐No ☐Unk		

Nausea	☐Yes ☐No ☐Unk		
Vomiting	☐Yes ☐No ☐Unk		
Diarrhea (>3 loose stools/day)	☐Yes ☐No ☐Unk		
Chest Pain	☐Yes ☐No ☐Unk		
Muscle aches (myalgia)	☐Yes ☐No ☐Unk		
Headache	☐Yes ☐No ☐Unk		
Dizziness	☐Yes ☐No ☐Unk		
Fatigue	☐Yes ☐No ☐Unk		
Altered Mental Status	☐Yes ☐No ☐Unk		
Seizures	☐Yes ☐No ☐Unk		
Other, specify:	☐Yes ☐No ☐Unk		
Other, specify:	☐Yes ☐No ☐Unk		

14. Did the patient seek medical care for this illness? ☐Yes ☐No ☐Unk
If, yes which type of facility: (Check all that apply) ☐Outpatient clinic ☐Urgent Care ☐Emergency department ☐Hospital
15. Was the patient hospitalized for the illness? (if yes, complete hospital form) ☐ Yes ☐ No ☐Unknown
16. Is the patient still hospitalized for this illness? ☐ Yes ☐ No ☐Unknown
17. Did the patient have an abnormal chest x-ray? ☐Yes ☐No ☐Unk ☐Not performed
18. Did the patient receive supplemental oxygen? ☐Yes ☐No ☐Unk
19. Was the patient admitted to the intensive care unit (ICU)? ☐Yes ☐No ☐Unk
20. Did the patient receive mechanical ventilation? ☐Yes ☐No ☐Unk
21. Was the patient on extra corporeal membranous oxygen (ECMO)? ☐Yes ☐No ☐Unk
22. Patient outcome due to illness: ☐Survived ☐Died ☐Unk

Medical History

23. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.

Chronic Lung Disease				
Asthma/reactive airway disease	☐Yes	☐No	☐Unknown	
Other chronic lung disease	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Diabetes Mellitus				
Diabetes Mellitus Type 1	☐Yes	☐No	☐Unknown	
Diabetes Mellitus Type 2	☐Yes	☐No	☐Unknown	
Hypertension	☐Yes	☐No	☐Unknown	
Chronic heart or cardiovascular disease	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Chronic kidney disease	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Liver disease	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Non-cancer immunosuppressive condition or treatment	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Cancer chemotherapy in past 12 months	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Neurologic/neurodevelopmental disorder	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other, specify:	☐Yes	☐No	☐Unknown	(If YES, specify) _____

24. Was patient pregnant at illness onset?
☐Yes, weeks pregnant at onset_____ ☐No ☐Unknown
25. Was patient ≤6 weeks postpartum at illness onset?
☐Yes, postpartum (delivery date) ___/___/___ (MM/DD/YYYY) ☐No ☐Unknown

26. Has the patient ever smoked? ☐Yes ☐No ☐Unknown
27. Does the patient currently smoke? ☐Yes ☐No ☐Unknown
28. Does the patient currently smoke e-cigarettes? ☐Yes ☐No ☐Unknown

2019-nCoV Laboratory Testing

(For each specimen type, please report earliest positive specimen, or earliest collected if all negative)

Specimen Type	Date of Collection	Test Result
NP Swab	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
OP Swab	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Sputum	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Bronchoalveolar lavage (BAL) fluid	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Tracheal fluid	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Stool	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Urine	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
Serum	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

Other, specify____	__/__/____ (MM/DD/YYYY)	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

Exposure

29. In the **14 DAYS prior to illness**, did the case-patient travel outside of the United States? ☐Yes ☐No ☐Unknown
    If yes, city_____ state/province _____ country_____ Dates of travel: (MM/DD/YYYY) ___/___/___ - ___/___/___
    If yes, city_____ state/province _____ country_____ Dates of travel: (MM/DD/YYYY) ___/___/___ - ___/___/___
    If yes, city_____ state/province _____ country_____ Dates of travel: (MM/DD/YYYY) ___/___/___ - ___/___/___
30. In the **14 DAYS prior to illness**, did the case-patient travel outside of their state of residence? ☐Yes ☐No ☐Unknown
    If yes, city_____ county _____ state_____ Dates of travel: (MM/DD/YYYY) ___/___/___ - ___/___/___
    If yes, city_____ county _____ state_____ Dates of travel: (MM/DD/YYYY) ___/___/___ - ___/___/___
    If yes, city_____ county _____ state_____ Dates of travel: (MM/DD/YYYY) ___/___/___ - ___/___/___
31. In the **14 DAYS prior to illness**, did the patient:

Have close contact with a confirmed 2019-nCoV case-patient?	☐Yes	☐No	☐Unknown
Have close contact with any household members, friends, acquaintances, or co-workers who had symptoms like the case-patient's?	☐Yes	☐No	☐Unknown
Visit a live animal market? If yes, specify _____	☐Yes	☐No	☐Unknown
Work or volunteer in a healthcare setting?	☐Yes	☐No	☐Unknown
Visit a healthcare setting?	☐Yes	☐No	☐Unknown

32. Was this patient under active or passive monitoring following exposure to a confirmed 2019-nCoV case-patient?
    ☐Yes ☐No ☐Unknown

Internal use
CDC nCoV ID _____

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2019 novel coronavirus (2019-nCoV) patient under investigation (PUI) form

As soon as possible, notify and send completed form to: 1) your local/state health department, and 2) CDC: email (eocreport@cdc.gov, subject line: nCoV PUI Form) or fax (770-488-7107). If you have questions, contact the CDC Emergency Operations Center (EOC) at 770-488-7100.

Today's date_____ **State patient ID**_____ **NNDSS local record ID/Case ID**[1] _____ **State**___ **County**_____

Interviewer's name_____ **Phone**_____ **Email**_____

Physician's name _____ **Phone**_____ **Pager or Email**_____

Sex ☐ M ☐ F **Age**_____☐ yr ☐ mo **Residency** ☐ US resident ☐ Non-US resident, country_____

PUI Criteria

Date of symptom onset_____

Does the patient have the following signs and symptoms (check all that apply)?

☐ Fever[2] ☐ Cough ☐ Sore throat ☐ Shortness of breath

In the 14 days before symptom onset, did the patient:

Spend time in Wuhan City, China? Does the patient live in Wuhan City? ☐ Y ☐ N ☐ Unknown Date traveled **to** Wuhan City_____ Date traveled **from** Wuhan City_____ Date **arrived** in US_____	☐ Y ☐ N ☐ Unknown
Have close contact[3] with a person who is under investigation for 2019-nCoV while that person was ill?	☐ Y ☐ N ☐ Unknown
Have close contact[3] with a laboratory-confirmed 2019-nCoV case while that case was ill?	☐ Y ☐ N ☐ Unknown

Additional Patient Information

Is the patient a health care worker? ☐ Y ☐ N ☐ Unknown

Have history of being in a healthcare facility (as a patient, worker, or visitor) in Wuhan City, China? ☐ Y ☐ N ☐ Unknown

Is patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which nCoV is being evaluated? ☐ Y ☐ N ☐ Unknown

Does the patient have these additional signs and symptoms (check all that apply)?

☐ Chills ☐ Headache ☐ Muscle aches ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Other, Specify_____

Diagnosis (select all that apply): Pneumonia (clinical or radiologic) ☐ Y ☐ N Acute respiratory distress syndrome ☐ Y ☐ N

Comorbid conditions (check all that apply): ☐ None ☐ Unknown ☐ Pregnancy ☐ Diabetes ☐ Cardiac disease ☐ Hypertension ☐ Chronic pulmonary disease ☐ Chronic kidney disease ☐ Chronic liver disease ☐ Immunocompromised ☐ Other, specify

Is/was the patient: Hospitalized? ☐ Y, admit date_____ ☐ N **Admitted to ICU?** ☐ Y ☐ N

Intubated? ☐ Y ☐ N **On ECMO?** ☐ Y ☐ N **Patient died?** ☐ Y ☐ N

Does the patient have another diagnosis/etiology for their respiratory illness? ☐ Y, Specify_____ ☐ N ☐ Unknown

Respiratory diagnostic results

Test	Pos	Neg	Pending	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐

Test	Pos	Neg	Pending	Not done
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify_____	☐	☐	☐	☐

Specimens for 2019-nCoV testing

Specimen type	Specimen ID	Date collected	Sent to CDC?
NP swab			☐
OP swab			☐
Sputum			☐
BAL fluid			☐
Tracheal aspirate			☐

Specimen type	Specimen ID	Date collected	Sent to CDC?
Stool			☐
Urine			☐
Serum			☐
Other, specify____			☐
Other, specify____			☐

[1] *For NNDSS reporters, use GenV2 or NETSS patient identifier.*

[2] *Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations*

[3] *Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection); or b) having direct contact with infectious secretions*

(e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……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……

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person?
- ☐ PUI, testing pending
- ☐ PUI, tested negative
- ☐ Presumptive case (positive local test), confirmatory testing pending
- ☐ Presumptive case (positive local test), confirmatory tested negative
- ☐ Laboratory-confirmed case
- ☐ Probable case

Report date of PUI to CDC (MM/DD/YYYY):
____/_____/_____

Report date of case to CDC (MM/DD/YYYY):
____/_____/_____

County of residence: _____
State of residence: _____

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/ Latino
- ☐ Not specified

Sex:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Other

Race (check all that apply):
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other, specify: _____
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Unknown

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____
Age units(yr/mo/day): _____

Date of first positive specimen collection (MM/DD/YYYY):
____/_____/_____
☐ Unknown ☐ N/A

Did the patient develop pneumonia?
☐ Yes ☐ Unknown ☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown ☐ No

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown ☐ No

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ Unknown ☐ No

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1
___/___/___ (MM/DD/YYYY)
If yes, discharge date 1
__/___/____ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days)
_____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY):
____/_____/_____
☐ Unknown date of death

Symptoms present during course of illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Unknown

If symptomatic, onset date (MM/DD/YYYY):
____/_____/_____
☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY):
____/_____/_____
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐ Yes ☐ No ☐ Unknown
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
- ☐ Travel to Wuhan
- ☐ Travel to Hubei
- ☐ Travel to mainland China
- ☐ Travel to other non-US country specify:_____
- ☐ Household contact with another lab-confirmed COVID-19 case-patient
- ☐ Community contact with another lab-confirmed COVID-19 case-patient
- ☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient ☐ Patient ☐ Visitor ☐ HCW
- ☐ Animal exposure
- ☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
- ☐ Other, specify:_____
- ☐ Unknown

If the patient had contact with another COVID-19 case, was this person a U.S. case? ☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A

Under what process was the PUI or case first identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX notification of travelers; if checked, DGMQID_____
☐ Unknown ☐ Other, specify:_____

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C)[c]	☐Yes ☐No ☐Unk
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk
Chills	☐Yes ☐No ☐Unk
Muscle aches (myalgia)	☐Yes ☐No ☐Unk
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk
Sore throat	☐Yes ☐No ☐Unk
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk
Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk
Nausea or vomiting	☐Yes ☐No ☐Unk
Headache	☐Yes ☐No ☐Unk
Abdominal pain	☐Yes ☐No ☐Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unk
Other, specify:_____	

Pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unknown	
Diabetes Mellitus	☐Yes	☐No	☐Unknown	
Cardiovascular disease	☐Yes	☐No	☐Unknown	
Chronic Renal disease	☐Yes	☐No	☐Unknown	
Chronic Liver disease	☐Yes	☐No	☐Unknown	
Immunocompromised Condition	☐Yes	☐No	☐Unknown	
Neurologic/neurodevelopmental/intellectual disability	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐No	☐Unknown	(If YES, specify) _____
If female, currently pregnant	☐Yes	☐No	☐Unknown	
Current smoker	☐Yes	☐No	☐Unknown	
Former smoker	☐Yes	☐No	☐Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify:_____	☐	☐	☐	☐

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			☐		☐	
OP Swab			☐		☐	
Sputum			☐		☐	
Other, Specify: _____			☐		☐	

Additional State/local Specimen IDs: _____ _____ _____ _____ _____

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

Human Infection with 2019 Novel Coronavirus (nCoV)
Household Contact Questionnaire V1.5 rev 3/24/2020

(Household Transmission Investigation)

State: WI
Household ID: WI-_____
Study ID: WI-_____

This questionnaire is to be administered to each household member (excluding the index patient).

Interview Information

1. Date of Interview: ___/____/_____(MM/DD/YYYY)
2. Name of Interviewer: _____
3. Person completing the interview: ☐ Self ☐ Parent/guardian: _____
   ☐ Other: _____

Household Member Information

4. Household member's name: First:_____ Last:_____
5. Date of birth:_____/____/_____(MM/DD/YYYY)
6. Age: _____ ☐ years ☐ months ☐ days

7. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Not Specified
8. Race: ☐ White ☐ Black ☐ Asian
   ☐ Am Indian/Alaska Nat ☐ Nat Hawaiian/Other PI ☐ Other, specify:_____ ☐ Unknown

9. Sex: ☐ Male ☐ Female
10. What is your relationship to [*insert name of index patient*]?
    ☐ Spouse ☐ Child ☐ Parent ☐ Grandparent ☐ Sibling ☐ Employee ☐ Other _____

11. What is the highest level of education you have completed?
    ☐ Less than high school
    ☐ High school diploma/GED
    ☐ Some college credit, no degree
    ☐ Technical degree/Associate's degree
    ☐ Bachelor's degree (i.e., B.A., B.S.)
    ☐ Master's degree (i.e., MBA)
    ☐ Doctorate or professional degree

12. What is your occupation? _____

SARS-CoV-2 testing for household contacts

13. Have you been tested for coronavirus? ☐ Yes ☐ No
    If yes, please complete the following information:
    a. Date of specimen collection_____(MM/DD/YYYY)
    b. Result of test: ☐ Positive ☐ Negative ☐ Pending ☐ Don't know/other _____
    c. Date of test result_____(MM/DD/YYYY)
    d. Were you experiencing symptoms when you were tested? ☐ Yes ☐ No
       i. Describe:_____
    e. Date of symptom onset: _____(MM/DD/YYYY)

Notes:_____

Past Medical History

14. Please provide pre-existing medical conditions (complete regardless of age):

Human Infection with 2019 Novel Coronavirus (nCoV)
Household Contact Questionnaire V1.5 rev 3/24/2020

(Household Transmission Investigation)

State: WI
Household ID: WI-_____
Study ID: WI-_____

Asthma/reactive airway disease	☐ Yes	☐ No	☐ Unknown	
Emphysema/COPD	☐ Yes	☐ No	☐ Unknown	
Active tuberculosis	☐ Yes	☐ No	☐ Unknown	If YES, on treatment: ☐ Yes ☐ No ☐ Unknown
Any other chronic lung diseases	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Diabetes Mellitus	☐ Yes	☐ No	☐ Unknown	
Hypertension (high blood pressure)	☐ Yes	☐ No	☐ Unknown	
Coronary artery disease/heart attack	☐ Yes	☐ No	☐ Unknown	
Congestive heart failure	☐ Yes	☐ No	☐ Unknown	
Stroke	☐ Yes	☐ No	☐ Unknown	
Congenital heart disease	☐ Yes	☐ No	☐ Unknown	
Any other heart diseases	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Any kidney disorders? If YES, answer the following:	☐ Yes	☐ No	☐ Unknown	
End-stage renal disease/dialysis	☐ Yes	☐ No	☐ Unknown	
Renal insufficiency	☐ Yes	☐ No	☐ Unknown	
Other kidney diseases	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Any liver disorders? If YES, answer the following:	☐ Yes	☐ No	☐ Unknown	
Alcoholic liver disease	☐ Yes	☐ No	☐ Unknown	
Cirrhosis/End stage liver disease	☐ Yes	☐ No	☐ Unknown	
Chronic hepatitis B	☐ Yes	☐ No	☐ Unknown	
Chronic hepatitis C	☐ Yes	☐ No	☐ Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	☐ Yes	☐ No	☐ Unknown	
Other chronic liver diseases	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
HIV infection. If YES, answer the following:	☐ Yes	☐ No	☐ Unknown	
AIDS or CD4 count currently <200	☐ Yes	☐ No	☐ Unknown	
Ever receive a transplant? If YES, answer the following:	☐ Yes	☐ No	☐ Unknown	
Solid organ transplant				If YES, date: _____
Stem cell transplant (e.g., bone marrow transplant)	☐ Yes	☐ No	☐ Unknown	If YES, date: _____
Cancer: current/in treatment or diagnosed in last 12 months	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Immunosuppressive therapy/medications	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____ For what condition: _____
Other immunosuppressive conditions	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Any other chronic diseases	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Developmental or neurologic disorder. If YES, answer the following:	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____

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(Household Transmission Investigation)

State: WI
Household ID: WI-_____
Study ID: WI-_____

Chromosomal or genetic abnormality	☐ Yes	☐ No	☐ Unknown	If YES, specify:_____
Cerebral palsy	☐ Yes	☐ No	☐ Unknown	
Epilepsy	☐ Yes	☐ No	☐ Unknown	
Any other development or neurologic Disorder				If YES, specify:_____
Any other medical conditions as a child	☐ Yes	☐ No	☐ Unknown	If YES, specify: _____
Were you born premature?	☐ Yes	☐ No	☐ Unknown	If yes, gestation at birth:_____wks

15. [*If female*] Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown ☐ N/A
16. [*If female*] Are you postpartum (≤6 weeks postpartum)? ☐ Yes ☐ No ☐ Unknown ☐ N/A
17. [*If female*] Are you breastfeeding? ☐ Yes ☐ No ☐ Unknown ☐ N/A
18. [*If child <3 years*] Is your child being breastfed? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Smoking/Vaping

19. Do you currently smoke tobacco on a daily basis, less than daily, or not at all?
    ☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
20. [*If not a daily smoker*] In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?
    ☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown
21. Do you currently vape or use electronic cigarettes on a daily basis, less than daily, or not at all?
    ☐ Daily ☐ Less than daily ☐ Not at all ☐ Unknown

Symptoms Prior to Index Case's Onset

Note to interviewer: record symptom onset date of the index patient from household questionnaire cover sheet. Ask the interviewee to get a calendar or personal diary. ___/____/____ (MM/DD/YYYY)

22. Did you experience any symptoms of a respiratory illness in the **2 weeks prior** to [*insert name of index patient*] becoming ill?
    ☐ Yes ☐ No ☐ Unknown

Exposures Outside of the Household

Note to interviewer: remind the interviewee to consult a calendar or diary for the following questions.
Date of index patient symptom onset: ___/____/____(MM/DD/YYYY)
14 days prior to index patient's symptom onset: ___/____/____ (MM/DD/YYYY)

23. **Since [***14 days **PRIOR** to the index patient's symptom onset***]…**

Exposure	Answer
…have you traveled (internationally or within the U.S., or on a cruise)?	☐ Yes: with index patient ☐ Yes: w/o index patient ☐ No ☐ Unknown
…attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other events)?	☐ Yes: with index patient ☐ Yes: w/o index patient ☐ No ☐ Unknown

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…have close contact (e.g. caring for, speaking with, touching, physically within 6 feet) with any suspected or known COVID-19 case outside of the household?	☐ Yes: with index patient ☐ Yes: w/o index patient ☐ No ☐ Unknown
…work in a healthcare setting?	☐ Yes ☐ No ☐ Unknown If yes, what types of healthcare settings: ☐ Hospital ☐ Outpatient Clinic ☐ Emergency Dept ☐ Dental Clinic ☐ Dialysis Center ☐ ICU ☐ Long-term care facility ☐ Other, specify: _____ What type of job do you have at the healthcare setting? ☐ Admin staff ☐ Nurse/Nurse tech ☐ Doctor ☐ EMS ☐ Other, specify: _____
…visit a healthcare setting (e.g. visit someone or have an appointment -- at a hospital, ED, outpatient clinic, dental clinic, long-term care facility)?	☐ Yes ☐ No ☐ Unknown
…attend/work at a daycare?	☐ Yes ☐ No ☐ Unknown
…attend/work at a school?	☐ Yes ☐ No ☐ Unknown

Symptoms After the Index Case's Onset

Note to interviewer: record symptom onset date of the index patient from household questionnaire. Ask the interviewee to get a calendar or personal diary. ___/____/____ (MM/DD/YYYY)

24. Since **____/____/____, when [the index case] first became symptomatic, have you experienced any of the following symptoms?**	**Symptom Present?**
Fever >100.4F (38C)[c]	☐Yes ☐No ☐Unk
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk
Chills	☐Yes ☐No ☐Unk
Muscle aches (myalgia)	☐Yes ☐No ☐Unk
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk
Sore throat	☐Yes ☐No ☐Unk
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk

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(Household Transmission Investigation)

State: WI
Household ID: WI-_____
Study ID: WI-_____

Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk
Nausea/Vomiting	☐Yes ☐No ☐Unk
Headache	☐Yes ☐No ☐Unk
Abdominal pain	☐Yes ☐No ☐Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unk
Other, specify:	

25. What date did you **first** become symptomatic?
_____/____/_____(MM/DD/YYYY)

26. Are you currently experiencing any symptoms of a respiratory illness, such as fever, cough, or shortness of breath?
(*Note: Flag any symptomatic household members for workflow planning and offer of self-nasal swab during visit*)
☐ Yes ☐ No ☐ Unknown

Exposures to the Index Patient

Note to interviewer: record symptom onset date of the index patient from household questionnaire. Ask the interviewee to get a calendar or personal diary. ___/____/____ (MM/DD/YYYY)

27. **Since [***index case***]'s symptoms started on [***date of symptom onset of the index patient***], did you …….?**

Exposure	Answer
…spend more than 10 minutes within 6 feet of the index patient?	☐ Yes ☐ No ☐ Unknown
…have face to face contact with the index patient (i.e., within about 2 feet)?	☐ Yes ☐ No ☐ Unknown
…spend any time within 6 feet of the index patient while he/she was coughing or sneezing?	☐ Yes ☐ No ☐ Unknown
…shake hands with the index patient?	☐ Yes ☐ No ☐ Unknown
…hug the index patient?	☐ Yes ☐ No ☐ Unknown
…kiss the index patient?	☐ Yes ☐ No ☐ Unknown
…take an object handed from or handled by the index patient? (e.g., pen, paper, food, utensil, etc.)	☐ Yes ☐ No ☐ Unknown
…sleep in the same bedroom as the index patient?	☐ Yes ☐ No ☐ Unknown
…sleep in the same bed as the index patient?	☐ Yes ☐ No ☐ Unknown
…share a bathroom with the index patient?	☐ Yes ☐ No ☐ Unknown
…prepare food with the index patient?	☐ Yes ☐ No ☐ Unknown
…share meals with the index patient?	☐ Yes ☐ No ☐ Unknown
…eat from the same plate as the index patient?	☐ Yes ☐ No ☐ Unknown

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(Household Transmission Investigation)

State: WI
Household ID: WI-_____
Study ID: WI-_____

Exposure	Answer
…share a utensil with the index patient?	☐ Yes ☐ No ☐ Unknown
…share a drinking cup/glass with the index patient?	☐ Yes ☐ No ☐ Unknown
…travel in the same vehicle (car, bus, airplane), sitting within 6 feet of the index patient?	☐ Yes ☐ No ☐ Unknown

28. Did you serve as primary caretaker for the index patient while he/she was ill? ☐ Yes ☐ No ☐ Unknown

29. When was your last exposure (*include any exposures described above*) to [*name of the index patient*]?
_____/_____/_____(MM/DD/YYYY) ☐ Ongoing exposure

30. How many days have you spent in the household since [*date of symptom onset of index patient*]? _____

31. How many nights have you spent in the household since [*date of symptom onset of index patient*]? _____

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Human Infection with 2019 Novel Coronavirus (nCoV)
Household Questionnaire V1.4 rev 3/23/2020

(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

HOUSEHOLD QUESTIONNAIRE COVER SHEET

- **If there are multiple confirmed COVID-19 cases in the household at baseline, identify the case with the earliest symptom onset as the index patient.**

Index case information (fill out ahead of time from PUI/CRF and verify at time of questionnaire administration)

1. Index patient's name: First: _____ Last: _____
2. Phone number: _____
3. Address: _____

4. Index patient's study ID: _____
5. Index patient's date of birth: ____/_____/_____ (MM/DD/YYYY)

6. Date of symptom onset of the index patient: _____/____/_____(MM/DD/YYYY)
7. Date of specimen collection of index patient (first positive test): ____/____/_____ (MM/DD/YYYY)
8. Date index patient received test result: _____/____/_____(MM/DD/YYYY)

Household member(s) (fill out ahead of time and verify/complete at time of questionnaire)

Name (first last)	Study ID	Relationship to case	Age (yrs)	Sex	DOB	Phone number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

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Human Infection with 2019 Novel Coronavirus (nCoV)
Household Questionnaire V1.4 rev 3/23/2020

(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

HOUSEHOLD QUESTIONNAIRE

Note: This questionnaire is to be administered to each household at enrollment. If possible, the head of household should provide information for questionnaire.

Interview information

1. Date of Interview: MM / DD / YYYY
2. Name of Interviewer: _____

3. Name of household member providing information for interview: _____
   Head of household? ☐ Yes ☐ No If no, relationship to head of household: _____

4. Location of the interview:
   ☐ At the household
   ☐ Over the phone
   ☐ Other, specify: _____

Describing the household

5. Location of the household:
   County: _____ State: _____ ZIP Code: _____

6. Confirm the number of household members from the cover sheet: _____persons
   Note to interviewer: Include resident family members, live-in staff, and long-term visitors.

7. What is the highest level of education completed by the head of the household?
   ☐ Less than high school
   ☐ High school diploma/GED
   ☐ Some college credit, no degree
   ☐ Technical degree/Associate's degree
   ☐ Bachelor's degree (i.e., B.A., B.S.)
   ☐ Master's degree (i.e., MBA)
   ☐ Doctorate or professional degree

8. What is the occupation of the head of the household? _____

9. Do you live in a single-family home or multi-unit housing (like an apartment)?
   ☐ Single-family home ☐ Multi-unit housing ☐ Other (specify):_____

10. Do you own or rent your home? ☐ Own ☐ Rent

11. What is the approximate size of the residence: _____ square feet
12. Number of floors in the residence: _____
13. Number of bedrooms in the residence: _____
14. Number of bathrooms in the residence: _____

15. What type of heating does this residence have?
    ☐ Forced air ☐ Radiator ☐Other, specify:_____ ☐ Don't know

Human Infection with 2019 Novel Coronavirus (nCoV)
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(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

16. Since the index patient developed symptoms on [*insert date of symptom onset*]:
    a. Has air conditioning been used?
    ☐Yes ☐No
    b. Has the household opened windows for ventilation?
    ☐Yes ☐No
    c. Has any other form of ventilation (e.g. ceiling fans or portable fans) been used?
    ☐Yes ☐No

Index patient information

Note to interviewer: if the household member completing the interview is not the index patient, ask if the index patient is available for several questions.

17. Are you still experiencing symptoms related to your COVID-19 illness?
    ☐ Yes ☐ No ☐ Never had symptoms
    If no, what date were you back to normal health? MM / DD / YYYY

18. Since you developed respiratory illness, have you done any of the following at home? (*select all that apply*)
    ☐ Slept alone in a bed If yes, dates: _____
    ☐ Slept alone in separate bedroom If yes, dates: _____
    ☐ Used a private bathroom (not shared) If yes, dates: _____
    ☐ Wore personal protective equipment If yes, dates: _____
    ☐Mask ☐Gloves ☐Other: _____
    ☐ Other: _____ If yes, dates: _____

19. Which household member has been assisting you as your primary caretaker during your illness?
    Name: _____ ☐None ☐Unknown

20. What tasks has this primary caretaker assisted you with?
    ☐Taking temperature ☐Serving meals ☐Cleaning bedroom ☐Cleaning bathroom ☐Help with toileting
    ☐Other, specify _____

Other:

21. Does the household have pets? ☐Yes ☐No
    If yes, how many? _____ pets
    Note to the interviewer: only include mammalian pets (no livestock).

Species (dog, cat)	Age (yrs)	Indoor Pet? (y/n)	Signs of illness? (y/n)	If ill, date of illness onset
1.				
2.				
3.				
4.				

Notes:

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Day of follow-up: 0/14 (Date of specimen collection)
Date (MM/DD/YYYY): _____

Name (First Last): _____
Household ID: WI-_____
HH member ID: WI-_____

Household Member Symptom Diary

1. Who is providing this information today?

   ☐ Self ☐ Parent/guardian

   ☐ Other, specify name: _____; relationship: _____

2. What is the current time? _____ ☐ AM ☐ PM
3. Did you sleep in the household last night? ☐ Yes ☐ No
4. During the past 24 hours, have you experienced any of the following symptoms?

Symptom	**Experienced in the past 24 hours?**
Documented Fever >=100.4F (38C) Highest temp _____F	☐Yes ☐No ☐Unknown
Subjective fever (felt feverish)	☐Yes ☐No ☐Unknown
Chills	☐Yes ☐No ☐Unknown
Fatigue (tired)	☐Yes ☐No ☐Unknown
Headache	☐Yes ☐No ☐Unknown
Muscle aches	☐Yes ☐No ☐Unknown
Runny nose	☐Yes ☐No ☐Unknown
Sore throat	☐Yes ☐No ☐Unknown
Cough (new onset or worsening of chronic cough) ☐ Dry ☐ Productive	☐Yes ☐No ☐Unknown
Discomfort/burning while breathing	☐Yes ☐No ☐Unknown
Shortness of breath	☐Yes ☐No ☐Unknown
Wheezing	☐Yes ☐No ☐Unknown
Chest Pain	☐Yes ☐No ☐Unknown
Nausea/Vomiting	☐Yes ☐No ☐Unknown
Loss of taste ☐ Complete ☐ Partial	☐Yes ☐No ☐Unknown
Loss of smell ☐ Complete ☐ Partial	☐Yes ☐No ☐Unknown
Abdominal pain	☐Yes ☐No ☐Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unknown
Other, specify:	☐Yes ☐No ☐Unknown

Who should we contact for your daily reminder? ☐ Me ☐ Other family member _____

Preferred method of contact: ☐ Phone call ☐ Text ☐ Email

Phone/email:_____

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Human Infection with SARS-CoV-2

Household Animal Questionnaire

*This questionnaire is to be completed by primary caretaker **for each pet/companion animal** in the household.*

State/local ID: _____
Household ID: _____
Pet/Animal ID: _____

Date interview completed: / / (MM/DD/YYYY)
Interviewer Name:_____ State/Local Health Department_____
Who is providing information for this form?
□ Index COVID-19 patient
□ Other, specify name: _____ Relationship to index patient: _____
How many pets/companion animals belong to the household? _____ (Include service animals and any animals that primarily live outside if the household members consider them "pets" and interact with them regularly.)

1. Pet Name: _____ Pet ID (e.g. 01, 02, 03…): _____
    a. Primary Caretaker of [PET NAME]: _____
    b. Animal Type: ☐ Dog ☐ Cat ☐ Other (please describe) _____
        a. Breed _____
    c. Age of Pet (years/months): _____ years or months (Circle one)
    d. Sex of Pet: ☐ Male ☐ Female
        a. Has [PET NAME] been spayed/neutered: ☐ Yes ☐ No
2. Does [PET NAME] have any current health conditions? ☐ Yes ☐ No
    a. If yes, please describe these health conditions or illnesses including when they started:

Condition	Date Started	Medications or supplement for the condition

    b. Please describe any other medications or supplements that [PET NAME] takes.

3. On a regular day before [COVID-19 CASE] began home isolation, how long per day and what types of interaction (e.g., walking, grooming, petting, cuddling) did [COVID-19 CASE] usually have with [PET NAME]?
    a. Duration of interaction with pet per day:
    ☐<1 hour ☐ 1-3 hours ☐ 4-6 hours ☐ 7-9 hours ☐ 10-12 hours ☐ 12+ hours
    b. Types of interaction/contact with pet (mark all that apply):

☐Taking for walks	☐Petting	☐Sharing food
☐Grooming	☐Cuddling	☐Letting the pet lick their face or hands
☐Feeding	☐Sleeping in the same location	☐Other (please describe): _____

4. On a regular day since [COVID-19 case] started home isolation, how long per day and what types of interaction has [COVID-19 CASE] had with [PET NAME]?
    a. Duration of interaction with pet per day:
    ☐<1 hour ☐ 1-3 hours ☐ 4-6 hours ☐ 7-9 hours ☐ 10-12 hours ☐ 12+ hours
    b. Types of interaction/contact with pet (mark all that apply):

☐ Taking for walks	☐ Petting	☐ Sharing food
☐ Grooming	☐ Cuddling	☐ Letting the pet lick their face or hands
☐ Feeding	☐ Sleeping in the same location	☐ Other (please describe): _____

    c. Was [COVID-19 CASE] wearing any personal protective equipment (e.g. gloves or a cloth face covering)?
    ☐ Yes ☐ No
        a. If yes, please describe: _____

5. Is your pet: ☐ Primarily indoors, ☐ outdoors or ☐ both?
   a. If both, what percent of time is spent indoors? _____%
   b. Is [PET NAME] allowed anywhere in the house or restricted to certain areas? _____
   c. If restricted, specify where: _____

6. On a regular day since [COVID-19 case] started home isolation, where does [PET NAME] go outside of the home (mark all that apply)?

☐ On leash walks at park	☐ Dog park
☐ Free roaming in neighborhood/on property	☐ Doggy Daycare
☐ On leash walks in neighborhood/on property	☐ Service function (e.g. therapy dog)
☐ Indoors only	☐ Other (please describe): _____

7. Since [COVID-19 case] was diagnosed, has this pet developed any new health condition (mark all that apply)?

☐ Coughing	☐ Runny nose
☐ Sneezing	☐ Vomiting
☐ Difficulty breathing or shortness of breath	☐ Diarrhea
☐ Lethargy	☐ Other (please describe): _____

8. Have you/the patient heard or read about the CDC guidelines about a person who is sick restricting contact with pets in the house? ☐ Yes ☐ No

9. Is there any additional information you think we should know about [PET NAME]?
   a. If Yes: _____

10. Are there small pets in the household, such as rats, mice, hamsters, gerbils, rabbits, or guinea pigs? ☐ Yes ☐ No
    a. If Yes, please list the type of animal(s) and their name(s):

    b. If No → Thank you for your time and participation.

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Human Infection with 2019 Novel Coronavirus (nCoV)
Household Close-Out Form V1.1 4/6/2020

(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

HOUSEHOLD CLOSE-OUT FORM

Please fill out this form when scheduling the final household visit.

1. Date of questionnaire: ____/____/_____
2. Date of final household visit (i.e., last serum collection): ____/____/_____
3. Is there extended symptom monitoring for confirmed cases beyond the final household visit? ☐ Yes ☐ No
   If yes, please provide approximate end date of symptom monitoring for this household: ____/____/_____

4. Have you changed anything in your household behaviors to prevent spread in the family? *Check all that are mentioned and DO NOT read the choices. Only include behaviors/interventions since time of enrollment:*
   ☐ Ill person/people (or persons diagnosed with COVID-19) wore a mask in the home
   ☐ My family is wearing masks, regardless of symptoms
   ☐ Ill person/people (or persons diagnosed with COVID-19) slept in a different room
   ☐ Ill person/people (or persons diagnosed with COVID-19) used a separate bathroom
   ☐ Ill person/people (or persons diagnosed with COVID-19) eat separately
   ☐ Ill person/people (or persons diagnosed with COVID-19) moved out of the house
   ☐ Used bleach wipes on high touch surfaces
   ☐ Used Lysol/cleaning spray on high touch surfaces
   ☐ Used Lysol/cleaning spray frequently in the bathroom
   ☐ Used Lysol/cleaning spray on high touch surfaces
   ☐ My family is washing hands frequently.
   ☐ My family stopped sharing plates/utensils/cups/food.
   ☐ My family increased the use of fans/open windows to increase air flow.
   ☐ My family stopped sharing common items like towels.
   ☐ My family is wearing gloves in the home.
   ☐ Other: specify_____

Human Infection with 2019 Novel Coronavirus (nCoV)
Household Close-Out Form V1.1 4/6/2020
(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

If a family member mentions wearing masks, ask questions 5-6:

5. What type of masks were worn (*check all that apply)*:
   ☐ Cloth
   ☐ Medical/Surgical
   ☐ N-95
   ☐ Other, non-traditional mask (e.g., scarves, other barriers, etc.): specify_____

6. If there is more than 1 ill person (or persons diagnosed with COVID-19) in the household, did all ill people wear a mask? ☐ Yes ☐ No ☐ Not applicable

7. Did any household pets become sick during the follow-up period? ☐ Yes ☐ No ☐ Not applicable
   If yes, describe symptoms and duration: _____

8. Please provide details for each household member in the table below:

Name	**Study ID**	**Hospitalized due to COVID-19**	**If confirmed by PCR, provide preliminary determination of primary vs. secondary cases***	**Withdrawal?**
1.		☐ Yes ☐ No	☐ Primary case ☐ Secondary case if secondary, suspected outside infection? ☐Yes ☐No, explain: _____ _____ _____ ☐ N/A	Withdrawal? ☐ Yes ☐ No If withdraw, date of withdrawal: ____/____/_____ Reasons: ☐hospitalized, alive ☐deceased ☐moved ☐declined ☐other_____

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Human Infection with 2019 Novel Coronavirus (nCoV)
Household Close-Out Form V1.1 4/6/2020

(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

Name	Study ID	Hospitalized due to COVID-19	If confirmed by PCR, provide preliminary determination of primary vs. secondary cases*	Withdrawal?
2.		☐ Yes ☐ No	☐ Primary case ☐ Secondary case if secondary, suspected outside infection? ☐Yes ☐No, explain: _____ _____ _____ ☐ N/A	Withdrawal? ☐ Yes ☐ No If withdraw, date of withdrawal: ____/____/_____ Reasons: ☐hospitalized, alive ☐deceased ☐moved ☐declined ☐other_____
3.		☐ Yes ☐ No	☐ Primary case ☐ Secondary case if secondary, suspected outside infection? ☐Yes ☐No, explain: _____ _____ _____ ☐ N/A	Withdrawal? ☐ Yes ☐ No If withdraw, date of withdrawal: ____/____/_____ Reasons: ☐hospitalized, alive ☐deceased ☐moved ☐declined ☐other_____
4.		☐ Yes ☐ No	☐ Primary case ☐ Secondary case if secondary, suspected outside infection? ☐Yes ☐No, explain: _____ _____ _____ ☐ N/A	Withdrawal? ☐ Yes ☐ No If withdraw, date of withdrawal: ____/____/_____ Reasons: ☐hospitalized, alive ☐deceased ☐moved ☐declined ☐other_____

Human Infection with 2019 Novel Coronavirus (nCoV)
Household Close-Out Form V1.1 4/6/2020

(Household Transmission Investigation)

State: ____WI_____
Household ID: __WI-_____

Name	Study ID	Hospitalized due to COVID-19	If confirmed by PCR, provide preliminary determination of primary vs. secondary cases*	Withdrawal?
5.		☐ Yes ☐ No	☐ Primary case ☐ Secondary case if secondary, suspected outside infection? ☐Yes ☐No, explain: _____ _____ _____ ☐ N/A	Withdrawal? ☐ Yes ☐ No If withdraw, date of withdrawal: ____/____/_____ Reasons: ☐hospitalized, alive ☐deceased ☐moved ☐declined ☐other_____
*The determination can be made at the time the patient is confirmed to be positive (i.e., at baseline, an interim visit, or day 14)				

Notes for field investigators:

- Primary case/s
  - Primary case is the confirmed COVID-19 case with the earliest symptom onset in the household. Oftentimes, this will be the index patient.
  - If there are multiple household cases who have the earliest symptom onset (within a day; or, not within a day but they have a known common exposure), we will consider them as co-primary cases who introduced the virus into the household. Please check them as primary cases in the table.
- Secondary cases
  - Ideally, we'd like to identify secondary cases as household members who are subsequently infected by the primary case/s.
  - However, in practice, we may not be able to differentiate secondary vs. tertiary (or further generations of) transmission, or infections due to exposure outside of the household
  - Thus, for now, we plan to **consider all subsequent infections in the household as secondary cases**, and estimate the overall risk of infection (i.e., % household members subsequently infected) as a proxy for household secondary attack rate
    - This approach assumes that all subsequent infections in the household are due to exposures to the primary case/s
  - As the above assumption may be violated, please mark household cases with suspected/known infection due to outside sources as; as a sensitivity analysis, we will consider excluding them when estimating the secondary attack rate