COVID-19 QUESTIONNAIRE

ID NUMBER:								

FORM CODE: COV
VERSION: 1.0 05/28/2020

Event: _____

0a) Date of Collection ☐☐ / ☐☐ / ☐☐☐☐ 0b) Staff Code ☐☐☐

Instructions: This form should be completed by the coordinator while interviewing the participant over the phone or in person.

Interviewer: To help us better understand the health of all study participants during the COVID-19 pandemic, we would like to ask you additional questions about your possible exposure to this new virus. The interview will take us as little as 5 minutes, or as much as 30 minutes, depending on whether you have been diagnosed with COVID-19. This information will be handled in the same way as the other data we have collected by phone. If you would like, I can review that information with you now. *(Review initial phone consent if participant says they need it).*

0c) Would it be okay to ask you questions about COVID-19 related experiences today?

☐ No0
☐ Yes1→ **Go to 0d**

0c1) When would it be convenient to call back? ☐☐ / ☐☐ / ☐☐☐

Thank you. We will call again. → **End Form**

0d) May we also call you in the future to see how you are doing and ask you these questions again?

☐ No0
☐ Yes1

1. Have you had COVID-19, or the illness caused by the novel coronavirus?
   ☐ No0
   ☐ Yes, definitely1
   ☐ Maybe2

2. Has a healthcare provider ever told you that you had COVID-19?

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☐ No0→ **Go to 3**
☐ Yes, definitely1
☐ Yes, probably or suspected2

2a. Name of doctor/clinic/hospital: _____

2b. Street address of doctor/clinic/hospital: _____

2c. City of doctor/clinic/hospital: _____

2d. State of doctor/clinic/hospital: _____

2e. Zip code of doctor/clinic/hospital: _____

2f. Contact number of doctor/clinic/hospital: ☐☐☐ - ☐☐☐ - ☐☐☐☐

3. Did you have symptoms of COVID-19?

☐ No0
☐ Yes1

4. Did you have a positive test for COVID-19?

☐ No0
☐ Yes1

5. Did you have close contact with someone who had COVID-19?

☐ No0
☐ Yes1
☐ Unsure2

6. Have you been tested for coronavirus or COVID-19?

☐ No0 → **Go to 24**
☐ Yes1
☐ Unsure2 → **Go to 24**

7. How many times have you been tested (for both infection and/or immunity)? ☐☐ times

8. Have you ever been tested specifically for COVID-19 **infection**?

☐ No0→ **Go to 9**
☐ Yes1
☐ Unsure2→ **Go to 9**

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8a. What was the result?
- ☐ Positive1
- ☐ Negative0
- ☐ Unsure2

9. Have you ever been tested specifically for COVID-19 **immunity**?
- ☐ No0→ **Go to 10**
- ☐ Yes1
- ☐ Unsure2→ **Go to 10**

9a. What was the result?
- ☐ Positive1
- ☐ Negative0
- ☐ Unsure2

Please provide details regarding your first COVID-19 test:

10. What was the date of your first COVID-19 test? ☐☐/☐☐/☐☐☐☐

11. Reason for first COVID-19 test:

11a. I had symptoms of COVID-19
- ☐ No0
- ☐ Yes1

11b. Someone I know had symptoms of COVID-19
- ☐ No0
- ☐ Yes1

11c. A doctor told me to be tested for COVID-19
- ☐ No0
- ☐ Yes1

11d. I was worried about COVID-19
- ☐ No0
- ☐ Yes1

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11e. Other reason

☐ No0 → **Go to 12**

☐ Yes1

11e1. If other reason, please specify: _____

12. Type of test for **first** COVID-19 test:

12a. Nasopharyngeal swab

☐ No0

☐ Yes1

12b. Blood test

☐ No0

☐ Yes1

12c. Saliva test

☐ No0

☐ Yes1

12d. Other test

☐ No0 → **Go to 13**

☐ Yes1

12d1. If other test, please specify: _____

13. What was the result of your **first** COVID-19 test?

☐ Positive1→ **Go to 24**

☐ Negative0

☐ Unsure2

Please provide details regarding your most recent COVID-19 test:

14. Is your **most recent** COVID-19 test different from your **first** test described above?

☐ No0→ **Go to 19**

☐ Yes1

☐ Unsure2→ **Go to 19**

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15. Date of your **most recent** COVID-19 test? ☐☐/☐☐/☐☐☐☐

16. Reason for **most recent** COVID-19 test:

16a. I had symptoms of COVID-19
- ☐ No0
- ☐ Yes1

16b. Someone I know had symptoms of COVID-19
- ☐ No0
- ☐ Yes1

16c. A doctor told me to be tested for COVID-19
- ☐ No0
- ☐ Yes1

16d. I was worried about COVID-19
- ☐ No0
- ☐ Yes1

16e. Other reason
- ☐ No0 → **Go to 17**
- ☐ Yes1

16e1. If other reason, please specify: _____

17. Type of test for **most recent** COVID-19 test:

17a. Nasopharyngeal swab
- ☐ No0
- ☐ Yes1

17b. Blood test
- ☐ No0
- ☐ Yes1

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17c. Saliva test
- ☐ No0
- ☐ Yes1

17d. Other test
- ☐ No0 → **Go to 18**
- ☐ Yes1

17d1. If other test, please specify: _____

18. What was the result of your **most recent** COVID-19 test?
- ☐ Positive1 → **Go to 24**
- ☐ Negative0
- ☐ Unsure2

19. If you did not experience a positive result on your **first** or **most recent** COVID-19 test, have you ever had a positive COVID-19 test?
- ☐ No0 → **Go to 24**
- ☐ Yes1
- ☐ Unsure2 → **Go to 24**

20. Date of **first positive** COVID-19 test? ☐☐ / ☐☐ / ☐☐☐☐

21. Reason for this COVID-19 test:

21a. I had symptoms of COVID-19
- ☐ No0
- ☐ Yes1

21b. Someone I know had symptoms of COVID-19
- ☐ No0
- ☐ Yes1

21c. A doctor told me to be tested for COVID-19
- ☐ No0
- ☐ Yes1

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21d. I was worried about COVID-19
- ☐ No0
- ☐ Yes1

21e. Other reason
- ☐ No0 → **Go to 22**
- ☐ Yes1

21e1. If other reason, please specify: _____

22. Type of test for **first positive** COVID-19 test:

22a. Nasopharyngeal swab
- ☐ No0
- ☐ Yes1

22b. Blood test
- ☐ No0
- ☐ Yes1

22c. Saliva test
- ☐ No0
- ☐ Yes1

22d. Other test
- ☐ No0 → **Go to 23**
- ☐ Yes1

22d1. If other test, please specify: _____

23. Are you willing to send a copy of your COVID-19 result(s) to the study?
- ☐ No0
- ☐ Yes1

24. Have you had any x-ray or computed tomography (CAT) scans for suspected or diagnosed COVID-19?
- ☐ No0→ **Go to 28**
- ☐ Yes1

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25. Did you have a chest X-ray?
- ☐ No0
- ☐ Yes1

26. Did you have a CT scan of your lungs?
- ☐ No0
- ☐ Yes1

27. Are you willing to have your lung image(s) shared with the study?
- ☐ No0
- ☐ Yes1

28. Have you had an overnight stay in a hospital for suspected or diagnosed COVID-19?
- ☐ No0→ **Go to 41**
- ☐ Yes1

28a. While in the hospital, were you enrolled in a COVID-19 clinical trial?
- ☐ No0
- ☐ Yes1
- ☐ Unsure2

29. Approximately, how many nights were you in the hospital? ☐☐☐ nights

30. Date arrived: ☐☐/☐☐/☐☐☐☐

31. Date discharged: ☐☐/☐☐/☐☐☐☐

32. During your hospital stay, did you require oxygen by nasal cannula (in your nose)?
- ☐ No0→ **Go to 33**
- ☐ Yes1

32a. Number of days needed ☐☐☐ days

33. During your hospital stay, did you require oxygen by face mask?
- ☐ No0→ **Go to 34**
- ☐ Yes1

33a. Number of days needed ☐☐☐ days

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34. During your hospital stay, did you require "Intensive Care Unit" (ICU) monitoring?
- ☐ No0 → **Go to 35**
- ☐ Yes1

34a. Number of days needed ☐☐☐ days

35. During your hospital stay, did you require a breathing tube or ventilator?
- ☐ No0 → **Go to 36**
- ☐ Yes1

35a. Number of days needed ☐☐☐ days

36. During your hospital stay, did you require "ECMO" treatment?
- ☐ No0 → **Go to 37**
- ☐ Yes1

36a. Number of days needed ☐☐☐ days

37. Name of hospital: _____

38. Street address hospital: _____

38a. City of hospital: _____

38b. State of hospital: _____

38c. Zip code of hospital: _____

39. Contact number of hospital: ☐☐☐ - ☐☐☐ - ☐☐☐☐

40. When you were discharged, were you discharged to:
- ☐ Home1 → **Go to 41**
- ☐ Nursing facility2 → **Go to 41**
- ☐ Other3

40a. If other, please specify: _____

41. Do you know or do you believe that you had COVID-19?
- ☐ No0 → **Go to44**
- ☐ Yes1

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☐ Unsure$_2$→ **Go to44**

42. Have you recovered to your usual state of health from your COVID-19 illness?
☐ No$_0$→ **Go to 44**
☐ Yes$_1$
☐ Unsure$_2$→ **Go to44**

43. How long did it take for you to recover? ☐☐☐ days

NOTE: For the next question, choose the appropriate introduction based on the participant's condition.

For participants who do NOT know (or believe) they had a COVID-19 illness (answered 'No' to Q41):
If you have not had diagnosed or suspected COVID-19 illness, have you had any of the following symptoms since our last contact? We would like to know: when the symptom was at its worst, how much did it bother you, on a scale of 1 to 5, where 1 means "not at all," 2 means "a little bit," 3 means "somewhat," 4 means "quite a bit," and 5 means "very much." And, how many days the symptoms lasted. ***Modified InFLUenza Patient-Reported Outcome (FLU-PRO) Questionnaire***

For participants who have had diagnosed or suspected COVID-19 illness (answered 'Yes' to Q41):
During your COVID-19 illness, please tell us if you have/had worsening of the following symptoms compared to your usual state of health. We would like to know: when the symptom was at its worst, how much did it bother you, on a scale of 1 to 5, where 1 means "not at all," 2 means "a little bit," 3 means "somewhat," 4 means "quite a bit," and 5 means "very much." And, how many days the symptoms lasted. ***Modified InFLUenza Patient-Reported Outcome (FLU-PRO) Questionnaire***

44. Fever
☐ No$_0$→ **Go to 45**
☐ Yes$_1$

44a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all$_1$

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☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

44b. How long did the symptom last? ☐☐☐ days

45. Trouble breathing
☐ No0→ **Go to 46**
☐ Yes1

45a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all1
☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

45b. How long did the symptom last? ☐☐☐ days

46. Chest congestion
☐ No0→ **Go to 47**
☐ Yes1

46a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all1
☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

46b. How long did the symptom last? ☐☐☐ days

47. Chest tightness
☐ No0→ **Go to 48**
☐ Yes1

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47a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?

- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

47b. How long did the symptom last? ☐☐☐ days

48. Dry or hacking cough

- ☐ No 0 → **Go to 49**
- ☐ Yes 1

48a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?

- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

48b. How long did the symptom last? ☐☐☐ days

49. Wet or loose cough

- ☐ No 0 → **Go to 50**
- ☐ Yes 1

49a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?

- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

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49b. How long did the symptom last? ☐☐☐ days

50. Body aches or pains
☐ No0→ **Go to 51**
☐ Yes1

50a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all1
☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

50b. How long did the symptom last? ☐☐☐ days

51. Chills or shivering
☐ No0→ **Go to 52**
☐ Yes1

51a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all1
☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

51b. How long did the symptom last? ☐☐☐ days

52. Sore or painful throat
☐ No0→ **Go to 53**
☐ Yes1

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52a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

52b. How long did the symptom last? ☐☐☐ days

53. Congested or stuffy nose
- ☐ No 0 → **Go to 54**
- ☐ Yes 1

53a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

53b. How long did the symptom last? ☐☐☐ days

54. Runny or dripping nose
- ☐ No 0 → **Go to 55**
- ☐ Yes 1

54a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

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54b. How long did the symptom last? ☐☐☐ days

55. Diarrhea
☐ No0→ **Go to 56**
☐ Yes1

55a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all1
☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

55b. How long did the symptom last? ☐☐☐ days

56. Weak or tired
☐ No0→ **Go to 57**
☐ Yes1

56a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
☐ Not at all1
☐ A little bit2
☐ Somewhat3
☐ Quite a bit4
☐ Very much5

56b. How long did the symptom last? ☐☐☐ days

57. Loss of smell
☐ No0→ **Go to 58**
☐ Yes1

Powers, J. H., 3rd, Bacci, E. D., Guerrero, M. L., Leidy, N. K., Stringer, S., Kim, K., Memoli, M. J., Han, A., Fairchok, M. P., Chen, W. J., Arnold, J. C., Danaher, P. J., Lalani, T., Ridoré, M., Burgess, T. H., Millar, E. V., Hernández, A., Rodríguez-Zulueta, P., Smolskis, M. C., Ortega-Gallegos, H., … Ruiz-Palacios, G. M. (2018). Reliability, Validity, and Responsiveness of InFLUenza Patient-Reported Outcome (FLU-PRO©) Scores in Influenza-Positive Patients. *Value in health: the journal of the International Society for Pharmacoeconomics and Outcomes Research*, *21*(2), 210–218. https://doi.org/10.1016/j.jval.2017.04.014

57a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

57b. How long did the symptom last? ☐☐☐ days

58. Loss of taste
- ☐ No 0 → **Go to 59**
- ☐ Yes 1

58a. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5?
- ☐ Not at all 1
- ☐ A little bit 2
- ☐ Somewhat 3
- ☐ Quite a bit 4
- ☐ Very much 5

58b. How long did the symptom last? ☐☐☐ days

59. Did the participant have one or more symptoms?
- ☐ No 0 → **Go to 71**
- ☐ Yes 1

60. Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? ***Patient Global Rating of Flu Severity Instrument***
- ☐ Mild 1
- ☐ Moderate 2
- ☐ Severe 3
- ☐ Very severe 4

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61. Overall, when these symptoms were at their worst, did they interfere with your daily activities? ***Patient Global Assessment of Interference with Daily Activities***
- ☐ Not at all1
- ☐ A little bit2
- ☐ Somewhat3
- ☐ Quite a bit4
- ☐ Very much5

62. If you had any of the symptoms we talked about (44 through 58), did you take any medicines?
- ☐ No0→ **Go to 71**
- ☐ Yes1

63. Did you take Acetaminophen, Tylenol?
- ☐ No0→ **Go to 64**
- ☐ Yes1

63a. Was it prescribed by a healthcare professional?
- ☐ No0
- ☐ Yes1

63b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

63c. What were the total number of days you took it? ☐☐☐ days

63d. What was the specific name of the medication? _____

64. Did you take Ibuprofen, Motrin, Advil, Aleve?
- ☐ No0→ **Go to 65**
- ☐ Yes1

64a. Was it prescribed by a healthcare professional?
- ☐ No0
- ☐ Yes1

64b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

64c. What were the total number of days you took it? ☐☐☐ days

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64d. What was the specific name of the medication? _____

65. Did you take cough medicine, Robitussin?
- ☐ No0→ **Go to 66**
- ☐ Yes1

65a. Was it prescribed by a healthcare professional?
- ☐ No0
- ☐ Yes1

65b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

65c. What were the total number of days you took it? ☐☐☐ days

65d. What was the specific name of the medication? _____

66. Did you take "cold and flu" medicine?
- ☐ No0→ **Go to 67**
- ☐ Yes1

66a. Was it prescribed by a healthcare professional?
- ☐ No0
- ☐ Yes1

66b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

66c. What were the total number of days you took it? ☐☐☐ days

66d. What was the specific name of the medication? _____

67. Did you take antibiotic (e.g. Azithromycin, Augmentin, Ciprofloxacin)?
- ☐ No0→ **Go to 68**
- ☐ Yes1

67a. Was it prescribed by a healthcare professional?
- ☐ No0
- ☐ Yes1

67b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

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67c. What were the total number of days you took it? ☐☐☐ days

67d. What was the specific name of the medication? _____

68. Did you take oral corticosteroids (e.g. Prednisone, Prednisolone, Methylprednisone)?
☐ No0→ **Go to 69**
☐ Yes1

68a. Was it prescribed by a healthcare professional?
☐ No0
☐ Yes1

68b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

68c. What were the total number of days you took it? ☐☐☐ days

68d. What was the specific name of the medication? _____

69. Did you take inhaled corticosteroids (e.g. Flovent, Symbicort, Advair)?
☐ No0→ **Go to 70**
☐ Yes1

69a. Was it prescribed by a healthcare professional?
☐ No0
☐ Yes1

69b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

69c. What were the total number of days you took it? ☐☐☐ days

69d. What was the specific name of the medication? _____

70. Did you take any other medications?
☐ No0→ **Go to 71**
☐ Yes1

70a. Was it prescribed by a healthcare professional?
☐ No0
☐ Yes1

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70b. What date did you start taking it? ☐☐/☐☐/☐☐☐☐

70c. What were the total number of days you took it? ☐☐☐ days

70d. What was the specific name of the medications?

70d1. _____

70d2. _____

70d3. _____

70d4. _____

71. How many people in your household (or the place you are residing) other than yourself have been tested for COVID-19?
- ☐ None or live alone0→ **Go to 90**
- ☐ One person1
- ☐ Two people2
- ☐ Three people3
- ☐ More than three people4

Household Member 1

72. Date when the test was conducted? ☐☐/☐☐/☐☐☐☐

73. What was the test result?
- ☐ Positive1
- ☐ Negative2
- ☐ Unsure3

74. Did you change your behavior at home?
- ☐ No0
- ☐ Yes1

75. Did you wear a mask at home?
- ☐ No0
- ☐ Yes1

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76. Did the infected person wear a mask at home?
- ☐ No0
- ☐ Yes1

77. Did the infected person stay away from you?
- ☐ No0
- ☐ Yes1

Household Member 2

78. Date when the test was conducted? ☐☐/☐☐/☐☐☐☐

79. What was the test result?
- ☐ Positive1
- ☐ Negative2
- ☐ Unsure3

80. Did you change your behavior at home?
- ☐ No0
- ☐ Yes1

81. Did you wear a mask at home?
- ☐ No0
- ☐ Yes1

82. Did the infected person wear a mask at home?
- ☐ No0
- ☐ Yes1

83. Did the infected person stay away from you?
- ☐ No0
- ☐ Yes1

Household Member 3

84. Date when the test was conducted? ☐☐/☐☐/☐☐☐☐

85. What was the test result?
- ☐ Positive1
- ☐ Negative2
- ☐ Unsure3

86. Did you change your behavior at home?
- ☐ No0
- ☐ Yes1

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87. Did you wear a mask at home?
- ☐ No0
- ☐ Yes1

88. Did the infected person wear a mask at home?
- ☐ No0
- ☐ Yes1

89. Did the infected person stay away from you?
- ☐ No0
- ☐ Yes1

90. What actions have you taken to reduce your risk of exposure to COVID-19?

	No0	Yes1	N/A2
90a. Washing hands and/or using sanitizer frequently	☐	☐	☐
90b. Staying at least 6 feet away from others	☐	☐	☐
90c. Avoiding large gatherings	☐	☐	☐
90d. Not going out to restaurants or bars	☐	☐	☐
90e. Cancelled planned travel	☐	☐	☐
90f. Wearing a face mask	☐	☐	☐
90g. Not shaking hands or touching people	☐	☐	☐
90h. Staying home when I am sick	☐	☐	☐
90i. Not going to work	☐	☐	☐
90j. Wiping down surfaces with disinfectant	☐	☐	☐
90k. Following government guidelines or rules to stay at home and limiting contacts with other people	☐	☐	☐
90l. Placed under full quarantine by local authorities	☐	☐	☐

Powers, J. H., 3rd, Bacci, E. D., Guerrero, M. L., Leidy, N. K., Stringer, S., Kim, K., Memoli, M. J., Han, A., Fairchok, M. P., Chen, W. J., Arnold, J. C., Danaher, P. J., Lalani, T., Ridoré, M., Burgess, T. H., Millar, E. V., Hernández, A., Rodríguez-Zulueta, P., Smolskis, M. C., Ortega-Gallegos, H., … Ruiz-Palacios, G. M. (2018). Reliability, Validity, and Responsiveness of InFLUenza Patient-Reported Outcome (FLU-PRO©) Scores in Influenza-Positive Patients. *Value in health: the journal of the International Society for Pharmacoeconomics and Outcomes Research*, *21*(2), 210–218. https://doi.org/10.1016/j.jval.2017.04.014

91. Do you currently use any of the following tobacco products?

91a. Cigarettes?
- ☐ No0 → **Go to 91b**
- ☐ Yes1

91a1. Number of cigarettes per day: ☐☐

91b. Pipes?
- ☐ No0
- ☐ Yes1

91c. Cigars?
- ☐ No0
- ☐ Yes1

91d. E-cigarettes?
- ☐ No0
- ☐ Yes1

91e. Other?
- ☐ No0 → **Go to 92**
- ☐ Yes1

91e1. If other, please specify: _____

92. Did you receive vaccinations for influenza (“the flu shot”) between September 2019 and March 2020?
- ☐ No0
- ☐ Yes1
- ☐ Don’t know2

93. Have you had a test for influenza since January 2020?
- ☐ No0 → **Go to End**
- ☐ Yes1
- ☐ Don’t know2 → **Go to End**

93a. What was the flu test result?
- ☐ Positive1
- ☐ Negative2
- ☐ Don’t know3

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93b. Was this test performed at the same time as a COVID-19 test?

- ☐ No0
- ☐ Yes1
- ☐ Don't know2

END OF FORM

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