Collaborative Cohort of Cohorts *for* COVID-19 Research

***About:*** This questionnaire was developed by C4R, the Collaborative Cohort of Cohorts for COVID-19 Research and is approved by the Columbia University Irving Medical Center IRB (AAAT3035), Principal Investigators: Elizabeth C. Oelsner, MD, MPH & Graham Barr, MD, DrPH.

***Purpose:*** The purpose of this questionnaire is to ascertain data on COVID-19 testing, self-reported COVID-19 diagnoses and hospitalizations, symptoms, recovery, re-infection, and vaccination. It also assesses the impact of the pandemic on access to healthcare, finances, health-related behaviors, social interactions, and mood.

***Content:*** This questionnaire can be administered to individuals with no prior COVID assessments as well as those with prior COVID assessments. If prior assessments are available, text is provided to guide the interviewer to gather new information.

***Mode of Administration:*** by telephone, mailed booklet, email, or online portal.

***Time to complete:*** depending on the mode of administration and the respondent's COVID history, the questionnaire may take between 5 and 60 minutes to complete.

***Additional Resources:*** Redcap data dictionary and codebook are available upon request. Investigators interested in learning more about C4R can visit https://c4r-nih.org.

***Participating Cohorts****:* This questionnaire incorporates input from and will be deployed across 14 NIH-funded cohorts participating in C4R: Atherosclerosis Risk in Communities (ARIC); Coronary Artery Risk Development in Young Adults (CARDIA) Study; Genetic Epidemiology of COPD (COPDGene); Familial Interstitial Pneumonia (FIP); Framingham Heart Study (FHS); Hispanic Community Health Study (Study of Latinos (HCHS/SOL); Jackson Heart Study (JHS); Mediators of Atherosclerosis in South Asians Living in America (MASALA) Study; Multi-Ethnic Study of Atherosclerosis (MESA); Northern Manhattan Study (NOMAS); REasons for Geographic and Racial Differences in Stroke (REGARDS); Severe Asthma Research Program (SARP): Subpopulations and Intermediate Outcome Measures in COPD Study (SPIROMICS); Strong Heart Study (SHS).

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***Suggested citation:*** C4R Investigators (2020) C4R Questionnaire.

Collaborative Cohort of Cohorts *for* COVID-19 Research

**Citations**

The C4R Questionnaire Subcommittee adapted items from the following survey instruments:


- Oelsner MESA COVID-19 Questionnaire 2020 [Available from: https://www.phenxtoolkit.org/toolkit_content/PDF/MESA_Questionnaire_Annotated.pdf.]
- MACS/WIHS-CSS. COVID-19 Questionnaire 2020 [Available from: https://www.phenxtoolkit.org/toolkit_content/PDF/MACS-WIHS.pdf.]
- HRS. COVID-19 Questionnaire 2020 [Available from: https://hrs.isr.umich.edu/sites/default/files/meta/2020/core/qnaire/online/05hr20COVID.pdf].
- USCD ABCD COVID-19 Impact Measure - Parent [Available from https://www.phenxtoolkit.org/toolkit_content/PDF/UCSD_ABCD_Parent.pdf.]
- BRFSS. Questionnaire 2019 [Available from: https://www.cdc.gov/brfss/questionnaires/pdf-ques/2019-BRFSS-Questionnaire508.pdf.]
- FLU-PRO Instrument, Global Rating of Flu Severity Instrument, Patient Global Assessment of Interference with Daily Activities (Powers JH, 3rd et al. Reliability, Validity, and Responsiveness of InFLUenza Patient-Reported Outcome (FLU-PRO(c)) Scores in Influenza-Positive Patients. Value Health. 2018;21:210-218.)
- Levine DW, Kripke DF, Kaplan RM, Lewis MA, Naughton MJ, Bowen DJ, et al. Reliability and validity of the Women's Health Initiative Insomnia Rating Scale. Psychol Assess. 2003;15(2):137-48.
- RAND. Social Support Survey Instrument [Available from: https://www.rand.org/health-care/surveys_tools/mos/social-support/survey-instrument.html.]
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- Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav. 1983;24(4):385-96.

# C4R Questionnaire

Participant ID #: ☐☐☐☐☐☐☐

Interviewer ID: ☐☐☐☐☐☐ Date: ☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

**COVID-19 Survey**

Greetings. Your responses to this survey will contribute to a better understanding of COVID-19 and the way it affects people like you.

If you have not had COVID-19, we expect that the survey will take 5 to 10 minutes. If you have been diagnosed with COVID-19, we will have some additional questions, so the survey may take up to 30 minutes or so. If you start the survey and need to continue later, you can scroll down and click the SUBMIT AND RETURN LATER button at the end – just be sure to record your return code.

Thank you so much for your participation in this important research.

Since your last COVID questionnaire

The last time we asked you about COVID-19 was [DATE]. At that time, you reported that you [HAD / had NOT] had COVID-19. The following questions will be about your experience since you completed the last COVID-19 questionnaire on [DATE].

**COVID-19 TESTING**

Since the last COVID-19 questionnaire, have you ever had any kind of test for COVID-19? Please include all types of tests that could show current or past infection (e.g., nose, spit, blood, PCR, antigen, or antibody tests).

- ○ Yes
- ○ No → **Skip to SELF REPORT**
- ○ Unsure →

If you'd like to provide some information on why you are unsure, please enter your comments here: _____

**Skip to SELF REPORT**

Why were you tested for COVID-19? *(Check all that apply)*

- ☐ I thought I might have had COVID-19
- ☐ I had symptoms of COVID-19
- ☐ Someone I spent time with had COVID-19
- ☐ A doctor told me to be tested for COVID-19
- ☐ A health department told me to be tested I
- ☐ was worried about COVID-19
- ☐ My employer or job required testing
- ☐ My school required testing
- ☐ I needed to be tested before a medical procedure
- ☐ I needed to be tested before or after traveling
- ☐ I needed to be tested to visit or provide care for a high risk person (e.g., older family member)
- ☐ Other: _____

Since the last COVID-19 questionnaire, have you ever had a test that showed you had COVID-19? Please include all types of tests.

- ○ Yes
- ○ No → **Skip to SELF REPORT**
- ○ Unsure →

If you'd like to provide some information on why you are unsure, please enter your comments here: _____

**Skip to SELF REPORT**

*If previously reported COVID infection:*
When was it that you had a test that showed you had COVID-19?

*If no past record of COVID infection:*
When was it that you first had a test that showed you had COVID-19?

Month: _____ Year: _____ (please estimate even if you are not sure)

What type of test was it? Pick one:

- ○ Nose ("nasal", "nasopharyngeal" swab)
- ○ Throat swab
- ○ Spit ("saliva") test
- ○ Blood test (including "blood draw," "dried blood spot," or "finger prick")
- ○ Other: _____

Would you be willing to send a copy of your COVID-19 results to the study?

- ○ Yes →
- ○ No

You are welcome to send your results in the following manner: [FILL IN COHORT PROCEDURES]

**Skip to COVID-19 REINFECTION**

**COVID-19 SELF-REPORT**

Since we know that some people may have had COVID-19 without having had a positive test, we want to ask a few more questions.

Since the last COVID questionnaire, do you think that you have had COVID-19?

- ○ Yes, definitely
- ○ Yes, I think so
- ○ Maybe → **Skip to HEALTHCARE PROVIDER**
- ○ No → **Skip to HEALTHCARE PROVIDER**

When did you think you had COVID-19?

Month: _____ Year: _____ (please estimate even if you are not sure)

Were you tested at that time?

- ○ Yes →

  What type of test was it? Pick one:

  - ○ Nose (“nasal”, “nasopharyngeal” swab)
  - ○ Throat swab
  - ○ Spit (“saliva”) test
  - ○ Blood test (including “blood draw,” “dried blood spot,” or “finger prick”)
  - ○ Other: _____

  Would you be willing to send a copy of your COVID-19 results to the study?

  - ○ Yes
  - ○ No

- ○ No →

  Why didn’t you get tested for COVID-19 at that time? Check all that apply:

  - ☐ I didn’t know how/where to get tested
  - ☐ It was hard to get tested (e.g., long lines)
  - ☐ I was afraid to get tested
  - ☐ I didn’t think I needed to be tested
  - ☐ I was worried about the cost
  - ☐ I was worried about the consequences of being diagnosed with COVID-19
  - ☐ A healthcare provider told me that a test was not necessary

**HEALTHCARE PROVIDER**

Since the last COVID questionnaire, has a healthcare provider ever told you that you had COVID-

- ○ Yes, definitely →
- ○ Yes, probably or suspected →
- ○ No

**If yes, did you have:**

a. Symptoms of COVID-19 ○ Yes ○ No

b. Close contact with someone who had COVID-19 ○ Yes ○ No

c. Other: _____

**If "No" to TEST POSITIVE, SELF-REPORT, AND HEALTHCARE PROVIDER:** Since we are interested in understanding the health effects of COVID-19, we would appreciate it if you would notify us if you are diagnosed with COVID-19. You are welcome to contact us in the following manner: _____. You are also welcome to send any COVID-19 test results in the following manner: [FILL IN COHORT PROCEDURES]

Then, **skip to COMMUNITY.**

**COVID-19 RE-INFECTION(for participants with no past record of COVID-19)**

You have reported that you know or think that you were infected with COVID-19 in [FILL IN MONTH, YEAR FROM ABOVE].

Has a healthcare provider ever told you that you may have gotten COVID-19 a second time, or that you have been "re-infected" with COVID019?

- ○ Yes
- ○ No ⟶ **Skip to HOSPITALIZATION**

Not counting your original infection, how many more times do you think you have been reinfected with COVID-19?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5

When do you know or think you were first re-infected with COVID-19?

Month: _____ Year: _____ (please estimate even if you are not sure)

At that time, what made you think you had been re-infected? Check all that apply:

- ☐ I had another test that showed that I had COVID-19
- ☐ I had symptoms of COVID-19 (fever, cough, trouble breathing)
- ☐ I had close contact with someone who had COVID-19
- ☐ Other: _____

This time, when you were re-infected, how did your symptoms compare to your first infection with COVID-19?

- ○ Worse than the first infection
- ○ About the same as the first infection
- ○ Better than the first infection
- ○ I had no symptoms

**Allow more fields depending on the number of re-infections**

Since we are interested in understanding the health effects of COVID-19, we would appreciate it if you would notify us if you are diagnosed again with COVID-19. You are welcome to contact us in the following manner: _____. You are also welcome to send any COVID-19 test results in the following manner: [FILL IN COHORT PROCEDURES]

**COVID-19 HOSPITALIZATION**

Since the last COVID-19 questionnaire, have you had an overnight stay in a hospital for any illness related to COVID-19?

- ○ Yes
- ○ No → **Skip to SYMPTOMS**
- ○ Unsure →

If you answer "unsure," we will not ask you any more questions about COVID-19 hospitalization. If you'd like to provide some information on why you are unsure, please enter your comments here:

_____

**Skip to SYMPTOMS**

*If previously reported COVID infection:*
Since the last COVID questionnaire, how many times have you been admitted to the hospital for COVID-19 or COVID-19 complications?

*If no past record of COVID infection:*
How many times have you been admitted to the hospital for COVID-19 or COVID-19 complications?

_____ times

*If previously reported COVID infection:*
Over this period, when was the first time you were hospitalized for COVID-19 or complications thereof?

*If no record of COVID infection:*
When was the first time you were hospitalized for COVID-19 or complications thereof?

Month: _____ Year: _____ (please estimate even if you are unsure)

Which hospital were you admitted to? (Name, City, State) _____

*If previously reported COVID infection:*
How many nights did you spend in the hospital?

*If no record of COVID infection:*
For the first hospital admission, how many nights did you spend in the hospital?

_____ nights

While in the hospital, did you have any of the following treatments?

| | Yes | No | Don't know | # Days needed |
|---|---|---|---|---|
| Oxygen (by mask or nose) | ○ | ○ | ○ | _____ |
| A breathing tube or ventilator | ○ | ○ | ○ | _____ |
| "Intensive care unit" or ICU monitoring | ○ | ○ | ○ | _____ |
| Dialysis | ○ | ○ | ○ | _____ |
| Other: _____ | ○ | ○ | ○ | _____ |

After this hospitalization, did you:

- ○ Return home?
- ○ Go to a nursing or rehabilitation facility?
- ○ Go to live in the home of family or a friend?
- ○ Other: _____

**If more than one hospitalization:**

When was the [FILL IN AS NEEDED, SECOND, THIRD, ETC] time you were hospitalized for COVID-19 or complications thereof?

Month: _____ Year: _____

Which hospital were you admitted to? (Name, City, State) _____

How many nights did you spend in the hospital? _____ nights

While in the hospital, did you have any of the following treatments?

| | Yes | No | Don't know | # Days needed |
|---|---|---|---|---|
| Oxygen (by mask or nose) | ○ | ○ | ○ | _____ |
| A breathing tube or ventilator | ○ | ○ | ○ | _____ |
| "Intensive care unit" or ICU monitoring | ○ | ○ | ○ | _____ |
| Dialysis | ○ | ○ | ○ | _____ |
| Other: _____ | ○ | ○ | ○ | _____ |

After this hospitalization, did you:

- ○ Return home?
- ○ Go to a nursing or rehabilitation facility?
- ○ Go to live in the home of family or a friend?
- ○ Other: _____

**COVID-19 SYMPTOMS**

*If previously reported COVID infection:*

When you knew or thought that you had COVID-19 in [FILL IN DATES FROM ABOVE REGARDING INFECTION], did you have any symptoms?

*If no past record of COVID infection:*

When you knew or thought that you had COVID-19 in [FILL IN DATES FROM ABOVE REGARDING FIRST INFECTION], did you have any symptoms?

- ○ Yes
- ○ No ⟶ **Skip to RECOVERY**

Overall, when you COVID-19 symptoms were at their worst, did they interfere with (prevent you from going about) your daily activities?

- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit
- ○ Very much

*If participant previously reported COVID infection:*

How did your symptoms compare to your first infection with COVID-19, which you reported on [DATE OF LAST QUESTIONNAIRE]?

- ○ Worse than the first infection
- ○ About the same as the first infection
- ○ Better than the first infection
- ○ I had no symptoms

*If previously reported COVID infection:*

When you had COVID-19 in [DATE], did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

*If no past record of COVID infection:*

When you had COVID-19, did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

| **Symptom** | **Yes** | **If yes:**<br>**How many days did you have the symptom?** | **If yes:**<br>**Do you still have the symptom?** |
|---|---|---|---|
| Fever | ☐ | | ◯ Yes ◯ No |
| Shortness of breath (trouble breathing) | ☐ | | ◯ Yes ◯ No |
| Cough | ☐ | | ◯ Yes ◯ No |
| Chest pain | ☐ | | ◯ Yes ◯ No |
| Abdominal pain | ☐ | | ◯ Yes ◯ No |
| Nausea | ☐ | | ◯ Yes ◯ No |
| Vomiting | ☐ | | ◯ Yes ◯ No |
| Diarrhea | ☐ | | ◯ Yes ◯ No |
| Body or muscle aches | ☐ | | ◯ Yes ◯ No |
| Weakness or fatigue | ☐ | | ◯ Yes ◯ No |
| Runny or dripping nose | ☐ | | ◯ Yes ◯ No |
| Chills | ☐ | | ◯ Yes ◯ No |
| Headache | ☐ | | ◯ Yes ◯ No |
| Sore throat | ☐ | | ◯ Yes ◯ No |
| Stuffy nose (nasal congestion) | ☐ | | ◯ Yes ◯ No |

***(continued)***

*If previously reported COVID infection:*

When you had COVID-19 in [DATE], did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

*If no past record of COVID infection:*

When you had COVID-19, did you have any of the following symptoms? Please check the box for any symptom that started or got worse during the period you had COVID-19. For any box checked, indicate the number of days that you had the symptom and whether you still have the symptom now.

| **Symptom** | **Yes** | **If yes:** **How many days did you have the symptom?** | **If yes:** **Do you still have the symptom?** |
|---|---|---|---|
| New loss of taste or smell | ☐ | | ◯ Yes ◯ No |
| Confusion | ☐ | | ◯ Yes ◯ No |
| Trouble sleeping | ☐ | | ◯ Yes ◯ No |
| Conjunctivitis | ☐ | | ◯ Yes ◯ No |
| Skin changes | ☐ | | ◯ Yes ◯ No |
| Other: _____ | ☐ | | ◯ Yes ◯ No |

**COVID-19 RECOVERY**

*If previously reported COVID infection:*

Following your COVID-19 infection in [FILL IN DATES FROM ABOVE REGARDING FIRST INFECTION AND REINFECTION], would you say you are completely recovered from COVID-19 now?

*If no past record of COVID infection:*

Following your COVID-19 infection in [FILL IN DATES FROM ABOVE REGARDING INFECTION], would you say you are completely recovered from COVID-19 now?

- ○ Yes → How long did it take for you to recover? _____ months _____ days
- ○ No

At this time, do you have any of the following symptoms? *(Check all that apply)*

- ☐ Problems with your memory
- ☐ Problems with paying attention
- ☐ Problems with your appetite
- ☐ Problems with feeling lightheaded
- ☐ Trouble sleeping
- ☐ Periods of racing heart rate
- ☐ Inability to exercise at pre COVID level
- ☐ Inability to return to work or school (if you were working or in school pre-COVID)
- ☐ Inability to return to your usual pre-COVID activities
- ☐ Feeling weak, tired and/or sick 24-48 hours after physical activity
- ☐ Other: _____

How worried are you that COVID-19 infection is going to have a long-term effect on your health?

- ○ Not at all worried
- ○ A little worried
- ○ Very worried

Is there anything else you'd like to share about your COVID-19 recovery experience?

_____

**COVID-19 IN YOUR COMMUNITY AND SOCIAL NETWORK**

Other than yourself, do you know anyone personally (for example, friend, family, or co-worker) who has had COVID-19? Please include people both with and without any symptoms of COVID-19.

- ○ Yes → If yes, how many? _____ (may be approximate)
- ○ No

Other than yourself, do you know anyone personally who has been hospitalized for COVID-19?

- ○ Yes → If yes, how many? _____ (may be approximate)
- ○ No

Do you know anyone personally who has died from COVID-19?

- ○ Yes → If yes, how many? _____ (may be approximate)
- ○ No

## COVID-19 VACCINE ATTITUDES AND BELIEFS

Have you received a vaccine for COVID-19?

- ○ Yes →
- ○ No
- ○ Unsure

When were you vaccinated? _____ month _____ year

Which vaccine did you receive?

- ○ Moderna
- ○ Pfizer
- ○ AstraZeneca
- ○ Unknown
- ○ Other: _____

How many doses did you receive?

- ○ One
- ○ Two

**Skip next question (Do you intend to receive a vaccine)**

Do you intend to receive a coronavirus (COVID-19) vaccine?

- ○ I intend to get it as soon as possible
- ○ I intend to wait to see how it affects others in the community before I get it
- ○ I do not intend on getting it soon, but might sometime in the future
- ○ I do not intend to ever get the vaccine

For these questions, we are asking what factors contribute to your attitudes about a COVID-19 vaccine. For each option, would you agree or disagree that this factor affects your opinion about a vaccine?

| | Agree | Disagree |
|---|---|---|
| The current politics | ○ | ○ |
| The rushed/ fast-tracked research and development timeline | ○ | ○ |
| The frequently changing science of COVID-19 | ○ | ○ |
| Actions and opinions of my friends and family regarding the vaccine | ○ | ○ |
| My trust in scientists | ○ | ○ |
| My own reading and research on coronavirus (COVID-19) vaccines | ○ | ○ |
| The country in which a vaccine is manufactured | ○ | ○ |
| The potential cost of a coronavirus (COVID-19) vaccine | ○ | ○ |
| Other (please specify): _____ | ○ | ○ |

| | Much less likely | Somewhat less likely | Somewhat more likely | A lot more likely | No change |
|---|---|---|---|---|---|
| When considering your willingness to vaccinate yourself in general, has the global Coronavirus (COVID19) pandemic changed how likely you are to vaccinate yourself compared with one year ago? | ○ | ○ | ○ | ○ | ○ |

Did you receive the influenza ("flu") vaccine this year (August 2020 or later)?

- ○ Yes
- ○ No
- ○ Unsure

Over the past five years, how often did you get the seasonal flu vaccine?

- ○ Never
- ○ 1-2 years
- ○ 3-4 years
- ○ Every year
- ○ Unsure

Have you received the pneumonia vaccine ("Pneumovax" or "Prevnar")?

- ○ Yes
- ○ No
- ○ Unsure

Have you received the shingles vaccine?

- ○ Yes
- ○ No
- ○ Unsure

How strongly do you agree or disagree with each of the following statements about vaccines in general?

| | Agree | Disagree |
|---|---|---|
| Vaccines are important for my health | ○ | ○ |
| Overall, vaccines are safe | ○ | ○ |
| Overall, vaccines are effective | ○ | ○ |
| The information I receive about vaccines from public health authorities/my healthcare provider is reliable and trustworthy | ○ | ○ |
| I am concerned about serious adverse (bad) effects of vaccines | ○ | ○ |

Please answer the following questions about your beliefs and attitudes regarding the seasonal influenza vaccine.

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| The flu vaccine is important | ○ | ○ | ○ | ○ |
| The flu vaccine is safe | ○ | ○ | ○ | ○ |
| The flu vaccine is effective | ○ | ○ | ○ | ○ |
| The flu vaccine is convenient | ○ | ○ | ○ | ○ |
| The flu vaccine is affordable | ○ | ○ | ○ | ○ |
| I am required to get a flu vaccine for my job | ○ | ○ | ○ | ○ |

## COVID-19 PANDEMIC IMPACT ON HEALTHCARE AND FINANCES

The next section of questions ask about how the coronavirus pandemic has impacted your life since March 2020, when the COVID-19 pandemic became widespread in the United States.

Since March 2020, did you have to delay or miss out on any healthcare services? Please include any appointments or treatments that you avoided, or that were postponed or canceled, due to COVID-19.

- ○ Yes
- ○ No

**If "No": skip to URGENT CARE**

What type of healthcare services did you have to delay or miss out on due to COVID-19? *(Check all that apply)*

- ☐ Home care by a skilled person
- ☐ Medical provider appointment
- ☐ Physical/occupational therapist appointment
- ☐ Chemotherapy or other infusion therapy
- ☐ Psychiatrist/therapist appointment
- ☐ Elective surgery
- ☐ Imaging tests such as x-ray, computed tomography ("cat" or "CT") scan, MRI, PET scan, ultrasound
- ☐ Biopsy
- ☐ Cancer surgery (e.g., resection, lumpectomy)
- ☐ Heart disease evaluation (e.g., "stress test," cardiac catheterization)
- ☐ Other: _____

Was there ever a time during the pandemic when you didn't go to the emergency room (ER) or urgent care when you should have gone?

- ○ Yes
- ○ No

Are you prescribed any medications?

- ○ Yes →
- ○ No

During this period, did you have trouble taking your medications regularly?

- ○ Yes →
- ○ No

Why? *(check all that apply)*

- ☐ Trouble getting medications from the pharmacy
- ☐ Trouble getting in touch with my doctor/provider
- ☐ Trouble paying for medications
- ☐ Increased forgetfulness or lack of motivation
- ☐ Other: _____

During this period, have you experienced any of the following:

| | Yes | No | Not Applicable |
|---|---|---|---|
| Did you or a member of your household lose their job, have to stop working, or have to work fewer hours? | ○ | ○ | ○ |

*If yes:*

Have you or another household member requested or received unemployment benefits?

- ○ Yes
- ○ No

| | Yes | No | Not Applicable |
|---|---|---|---|
| Did you lose childcare or need to spend more time caring for your or other people's children? | ○ | ○ | ○ |
| Did you or any member of your household lose other sources of financial support, like food stamps? | ○ | ○ | ○ |
| Did you lose your housing, or become homeless? | ○ | ○ | ○ |
| Did you have a change in your health insurance coverage? | ○ | ○ | ○ |

*If yes:*

Did you lose your health insurance?

- ○ Yes
- ○ No

Did you gain insurance as part of emergency coverage or Medicaid expansion?

- ○ Yes
- ○ No

Did you gain coverage due to a new job?

- ○ Yes
- ○ No

| | Yes | No | Not Applicable |
|---|---|---|---|
| Did you have difficulty paying for basic needs, including food, clothing, shelter or heat during this time? | ○ | ○ | ○ |

## COVID-19 PANDEMIC IMPACT ON BEHAVIOR

This is a list of potential actions we want to know if you have taken to reduce your risk of exposure to COVID-19. You can say “most or all of the time,” “sometimes,” or “rarely or never.”

| | Most/All Times | Sometimes | Rarely/ Never |
|---|---|---|---|
| Staying at home | ○ | ○ | ○ |
| Avoiding contact with people outside of my home | ○ | ○ | ○ |
| Washing hands and/or using sanitizer frequently | ○ | ○ | ○ |
| Staying at least 6 feet away from others | ○ | ○ | ○ |
| Avoiding large gatherings | ○ | ○ | ○ |
| Avoiding eating indoors at restaurants/bars | ○ | ○ | ○ |
| Cancelled planned travel | ○ | ○ | ○ |
| Wearing a face mask | ○ | ○ | ○ |
| Not shaking hands or touching people | ○ | ○ | ○ |
| Not going to work | ○ | ○ | ○ |
| Wiping down surfaces with disinfectant | ○ | ○ | ○ |

We would like to know how your activity may have changed since the start of the pandemic in March 2020.

| Activity | In the 3 months prior to the pandemic (January to March 2020), did you regularly do this activity? | | Are you doing this activity now? | | *If yes-prior and yes-now:* Compared to before the pandemic, are you doing this more, less, or the same amount? | | | |
|---|---|---|---|---|---|---|---|---|
| | No | Yes | No | Yes | More | Less | Same amount | |
| Walking for exercise | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |
| Vigorous activities (like running) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |
| Watching shows or movies | ○ | ○ | ○ | ○ | ○ | ○ | ○ | If doing this activity now, how much? |
| Drinking alcoholic beverages | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ____ drinks/week |
| Smoking cigarettes | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ____ cigarettes/day |
| E-cigarettes (vaping) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ____ e-cigarettes/day |
| Using medical or recreational marijuana/ cannabis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ____ uses/week |

During the pandemic, are you generally eating and snacking more, less, or the same?

- ○ More
- ○ Less
- ○ Same amount

Has your weight changed since March 2020?

- ○ Gained weight
- ○ Lost weight
- ○ No change in weight

Were you trying to change your weight since March 2020?

- ○ Yes
- ○ No

How does your general health compare to before the pandemic?

- ○ Better
- ○ Worse
- ○ About the same

During the pandemic, are you generally sleeping more, less, or the same?

- ○ More
- ○ Less
- ○ Same amount

These questions ask about your sleep habits. Pick the answer that best describes how often you experienced the situation over the PAST 4 WEEKS.

| | No, not in past 4 weeks | Yes, less than once a week | Yes, 1 or 2 times a week | Yes, 3 or 4 times a week | Yes, 5 or more times a week |
|---|---|---|---|---|---|
| Did you have trouble falling asleep? | ○ | ○ | ○ | ○ | ○ |
| Did you wake up several times at night? | ○ | ○ | ○ | ○ | ○ |
| Did you wake up earlier than you planned to? | ○ | ○ | ○ | ○ | ○ |
| Did you have trouble falling back asleep after you woke up too early? | ○ | ○ | ○ | ○ | ○ |

| | Very sound or restful | Sound or restful | Average quality | Restless | Very restless |
|---|---|---|---|---|---|
| Overall, was your typical night's sleep over the past 4 weeks... | ○ | ○ | ○ | ○ | ○ |

During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?

- ○ Yes
- ○ No

**COVID-19 PANDEMIC IMPACT ON SOCIAL INTERACTIONS**

Do you live alone?

- ○ Yes →
- ○ No

Other than yourself, how many people are currently sharing your home, and what are their ages?

| | |
|---|---|
| 0-1 years old: _____ | 40-49 years old: _____ |
| 2-4 years old: _____ | 50-64 years old: _____ |
| 5-11 years old: _____ | 65-74 years old: _____ |
| 12-18 years old: _____ | 75-84 years old: _____ |
| 19-29 years old: _____ | 85+ years old: _____ |
| 30-39 years old: _____ | |

Can you count on anyone to help you when you need to make difficult decisions or talk over problems?

- ○ Yes
- ○ No
- ○ Do not know

Can you count on anyone to help you with daily tasks like grocery shopping, house cleaning, cooking, telephoning, or giving you a ride?

- ○ Yes
- ○ No
- ○ Do not know

## COVID-19 PANDEMIC IMPACT ON MOOD

Here is a list of some ways you might have felt or behaved in the PAST WEEK. Please indicate how many days you have felt this way during the past week.

| | Rarely or none of the time (<1 day) | Some or a little of the time (1-2 days) | Occasionally or a moderate amount of the time (3-4 days) | All of the time (5-7 days) |
|---|---|---|---|---|
| I was bothered by things that usually don't bother me | ○ | ○ | ○ | ○ |
| I had trouble keeping my mind on what I was doing. | ○ | ○ | ○ | ○ |
| I felt depressed. | ○ | ○ | ○ | ○ |
| I felt that everything I did was an effort. | ○ | ○ | ○ | ○ |
| I felt hopeful about the future. | ○ | ○ | ○ | ○ |
| I felt fearful. | ○ | ○ | ○ | ○ |
| My sleep was restless. | ○ | ○ | ○ | ○ |
| I was happy. | ○ | ○ | ○ | ○ |
| I felt lonely. | ○ | ○ | ○ | ○ |
| I could not "get going." | ○ | ○ | ○ | ○ |

For the following list, please consider your feelings during the PAST WEEK.

| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|---|---|---|---|---|
| My worries overwhelmed me | ○ | ○ | ○ | ○ | ○ |
| I felt uneasy | ○ | ○ | ○ | ○ | ○ |
| I found it hard to focus on anything other than my anxiety | ○ | ○ | ○ | ○ | ○ |
| I felt fatigued | ○ | ○ | ○ | ○ | ○ |
| I had trouble starting things because I was tired | ○ | ○ | ○ | ○ | ○ |
| How run down did you feel on average? | ○ | ○ | ○ | ○ | ○ |
| How fatigued were you on average? | ○ | ○ | ○ | ○ | ○ |

Here is a statement about how you respond to stressful events.

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| I tend to bounce back quickly after hard times | ○ | ○ | ○ | ○ | ○ |

For each of the following items, please provide the response that describes your life.

| | Often | Some of the time | Hardly ever |
|---|---|---|---|
| How often do you feel that you lack companionship? | ○ | ○ | ○ |
| How often do you feel left out? | ○ | ○ | ○ |
| How often do you feel isolated from others? | ○ | ○ | ○ |

The questions in this scale ask you about your feelings and thoughts during the LAST MONTH. In each case, please indicate how often you felt or thought a certain way.

| | Never | Almost never | Sometimes | Fairly often | Often |
|---|---|---|---|---|---|
| In the last month, how often have you felt that you were unable to control the important things in your life? | ○ | ○ | ○ | ○ | ○ |
| In the last month, how often have you felt confident in your ability to handle your personal problems? | ○ | ○ | ○ | ○ | ○ |
| In the last month, how often have you felt that things were going your way? | ○ | ○ | ○ | ○ | ○ |
| In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? | ○ | ○ | ○ | ○ | ○ |

Is there anything else you'd like to share about how the COVID-19 pandemic has affected your mood or mindset?

_____

## COVID-19 BELIEFS AND ATTITUDES

Please indicate how much you agree or disagree with these statements.

| | Strongly Disagree | Disagree | Neither disagree nor agree | Agree | Strongly agree |
|---|---|---|---|---|---|
| I am worried that our family will experience racism or discrimination in relation to coronavirus | ○ | ○ | ○ | ○ | ○ |
| I have noticed increased conflict in our family since our area started worrying about coronavirus | ○ | ○ | ○ | ○ | ○ |
| I think all of this worry about coronavirus is blown out of proportion | ○ | ○ | ○ | ○ | ○ |
| I think it is likely that I will get coronavirus | ○ | ○ | ○ | ○ | ○ |
| I think it is likely I will be hospitalized or die from the coronavirus | ○ | ○ | ○ | ○ | ○ |
| I think it is likely that someone very close to me will get coronavirus | ○ | ○ | ○ | ○ | ○ |
| I think it is likely that someone very close to me will be hospitalized or die from the coronavirus | ○ | ○ | ○ | ○ | ○ |