

NIH RADx Executive Committee Required Common Data Elements (CDEs)

It is expected that all research involving human subjects funded in the RADx program will collect information on these 12 concepts using these questions and specified response options.

Contact Patti Brennan (pattifbrennan@nih.gov) with any questions.

Concept	Question Text	Allowable Responses
1. Identity		<i>Project-specific identifier</i>
2A. Race		
	What is your race? Mark one or more boxes.	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Some other race
2B. Ethnicity		
	Are you of Hispanic or Latino origin?	<input type="checkbox"/> Yes, of Hispanic or Latino origin <input type="checkbox"/> No, not of Hispanic or Latino origin
3. Age		
	What is your age?	<i>Age in years. For babies less than 1 year old, write 0 as the age</i>
4. Sex		
	What is your biological sex assigned at birth?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> None of these describe me
5. Education		
	How many years of education have you completed?	<i>Years of education from 0 – 20+</i>
6. Domicile		
	What is your zip code?	<i>5-digit zip code</i>
7. Employment		
	Are you employed?	<input type="checkbox"/> Employed in a permanent position <input type="checkbox"/> Employed in a temporary position <input type="checkbox"/> Not currently employed

8. Insurance status		
	What kind of health insurance do you have?	<input type="checkbox"/> Private insurance <input type="checkbox"/> Public insurance <input type="checkbox"/> None
9. Disability status		
	Are you deaf or do you have serious difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have serious difficulty walking or climbing stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have difficulty dressing or bathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Medical history		
	Vaping use	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nicotine use	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chronic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chronic lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Immunosuppressive condition	<input type="checkbox"/> Yes

		<input type="checkbox"/> No
	Serious mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Sickle cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pregnancy status	<input type="checkbox"/> Currently pregnant <input type="checkbox"/> Not pregnant

11. Symptoms

	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Shortness of breath or difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Muscle ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
	New loss of taste or smell	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Excessive fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nausea/vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No

12. Health status

	What is your height?	<i>Height in feet and inches</i>
	What is your weight?	<i>Weight in pounds</i>
	Would you say that (your) health in general is excellent, very good, good, fair or poor?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor