COVID-19 Questionnaire

Please complete the survey below.

Date of Birth *Required

__________________________________
(mm-dd-yyyy)

Initials

( Please write your FIRST and LAST initial only. )

1) Where do you CURRENTLY live? *Required

☐ Independent home or other housing in the general community
☐ Senior/retirement housing or community for people age 55+
☐ Assisted living facility
☐ Rehabilitation facility or skilled nursing facility
☐ Nursing home

2) With whom do you live? (Mark all that apply.) *Required

☐ Alone
☐ With spouse or partner
☐ With other family
☐ With non-relatives
QUESTIONS ABOUT CORONAVIRUS (COVID-19)

3) Have you been tested for the coronavirus (COVID-19, SARS-CoV-2)? *Required
   ○ No
   ○ Yes
   ○ Not Sure

Have you had at least one test with a POSITIVE result? *Required
[Only shows if "Yes" is selected for Question 3]
   ○ No
   ○ Yes
   ○ Not Sure

Please answer the following questions about the NEGATIVE test result(s) you received. [Only shows if "No" is selected for "Have you had at least one test with a POSITIVE result?"]

   How many times were you tested? *Required
   [Only shows if "No" or "Not Sure" is selected for "Have you had at least one test with a POSITIVE result?"]
   ○ 1 time
   ○ 2 times
   ○ 3 or more times
   ○ Not Sure

   Please answer the following questions about the POSITIVE test result(s) you received. [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

   When were you tested? Mark all that apply. *Required
   [Shows if "No" or "Yes" or "Not Sure" is selected for "Have you had at least one test with a POSITIVE result?"]
   ○ January
   ○ February
   ○ March
   ○ April
   ○ May

   Where was the test performed? Mark all that apply. *Required
   [Shows if "No" or "Yes" or "Not Sure" is selected for "Have you had at least one test with a POSITIVE result?"]
   ○ Hospital - Emergency Department
   ○ Hospital - Inpatient
   ○ Outpatient Clinic
   ○ Drive-Through
   ○ Other

The following question(s) are about ANY NEGATIVE test results you may have received. [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

   Have you had any negative test results? *Required
   [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]
   ○ No
   ○ Yes
   ○ Not Sure

   How many times have you had a negative test result? *Required
   [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]
   ○ 1 time
   ○ 2 times
   ○ 3 or more times
   ○ Not Sure

   Where was the test performed? Mark all that apply. *Required
   [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]
   ○ Hospital - Emergency Department
   ○ Hospital - Inpatient
   ○ Outpatient Clinic
   ○ Drive-Through
   ○ Other

4) Whether or not you have had a coronavirus test, has a doctor or another healthcare professional diagnosed you as having or probably having the coronavirus? *Required
   ○ No
   ○ Yes
   ○ Not Sure
5) To your knowledge, have you EVER been exposed to another person with confirmed or suspected COVID-19 as part of the pandemic? *Required

- Yes, confirmed COVID-19 case(s)
- Yes, suspected COVID-19 case(s) only
- Yes, both confirmed and suspected COVID-19 case(s)
- No, not that I know of

Were any of these cases a member of your household? *Required

- No
- Yes [Shows if "Yes..." is selected in the question above]
6) Since January 2020, have you had any of the following symptoms that may or may not be related to COVID-19?

<table>
<thead>
<tr>
<th></th>
<th>Fever</th>
<th>Persistent cough</th>
<th>Chills or sweats</th>
<th>Unusual fatigue</th>
<th>Headache</th>
<th>Unusual shortness of breath</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>*Required</td>
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<td>*Required</td>
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<td>○ No ○ Yes</td>
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<tr>
<td>When since January 2020?</td>
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<td>(Mark all that apply.)</td>
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</tbody>
</table>

b) Persistent cough (coughing a lot for more than 1 hour, or at least 3 coughing episodes in 24 hours)

<table>
<thead>
<tr>
<th></th>
<th>Fever</th>
<th>Persistent cough</th>
<th>Chills or sweats</th>
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<td>(Mark all that apply.)</td>
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</table>

c) Chills or sweats

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<th>Fever</th>
<th>Persistent cough</th>
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<td>When since January 2020?</td>
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</table>

d) Unusual fatigue

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<th>Chills or sweats</th>
<th>Unusual fatigue</th>
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<td>○ No ○ Yes</td>
<td>○ No ○ Yes</td>
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<td>What was the severity?</td>
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<td>☐ Mild Fatigue</td>
<td>☐ Severe Fatigue</td>
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<td>When since January 2020?</td>
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<td>(Mark all that apply.)</td>
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</table>

e) Headache

<table>
<thead>
<tr>
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<th>Fever</th>
<th>Persistent cough</th>
<th>Chills or sweats</th>
<th>Unusual fatigue</th>
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<tr>
<td>(Mark all that apply.)</td>
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<td>☐ January ☐ February ☐ March ☐ April ☐ May</td>
</tr>
</tbody>
</table>

f) Unusual shortness of breath

<table>
<thead>
<tr>
<th></th>
<th>Fever</th>
<th>Persistent cough</th>
<th>Chills or sweats</th>
<th>Unusual fatigue</th>
<th>Headache</th>
<th>Unusual shortness of breath</th>
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<tbody>
<tr>
<td>f)</td>
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<td>*Required</td>
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<td>○ No ○ Yes</td>
<td>○ No ○ Yes</td>
<td>○ No ○ Yes</td>
<td>○ No ○ Yes</td>
<td>○ No ○ Yes</td>
<td>○ No ○ Yes</td>
</tr>
<tr>
<td>What was the severity?</td>
<td>*Required</td>
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<tr>
<td></td>
<td>☐ Mild (slight shortness of breath during ordinary activity)</td>
<td>☐ Significant (breathing is comfortable only at rest)</td>
<td>☐ Severe (breathing is difficult even at rest)</td>
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</tr>
</tbody>
</table>
When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

g) Sore throat  *Required  ○ No  ○ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

h) Loss of smell  *Required  ○ No  ○ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

i) Loss of taste  *Required  ○ No  ○ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

j) Loss of appetite (including skipped or missed meals)  *Required  ○ No  ○ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

k) Unusually hoarse voice  *Required  ○ No  ○ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

l) Unusual chest pain or tightness in your chest  *Required  ○ No  ○ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January  ☐ February  ☐ March  ☐ April  ☐ May

m) Muscle or body aches  *Required  ○ No  ○ Yes
<table>
<thead>
<tr>
<th>Symptom</th>
<th>When since January 2020?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual abdominal pain</td>
<td>(Mark all that apply.)</td>
<td></td>
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<tr>
<td>Diarrhea</td>
<td>(Mark all that apply.)</td>
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<tr>
<td>Confusion, disorientation, or drowsiness</td>
<td>(Mark all that apply.)</td>
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</tbody>
</table>
7) Which of the following statements applies to you? Mark all that apply. *Required

- I haven't been to a clinic, emergency room, or hospital for suspected COVID-19 symptoms.
- I was evaluated at a clinic, emergency room, or hospital with suspected COVID-19 symptoms.
- I was hospitalized for COVID-19.

a) What treatment did you receive? Mark all that apply. *Required [Sub-questions for Question 7 (a-e) only show if "I was hospitalized for COVID-19" is selected]

- Intravenous fluids
- Oxygen through nasal (nose) prongs or facial mask, but not requiring a ventilator
- Invasive ventilation or ventilator (Breathing support through an inserted tube. People are usually asleep for this procedure.)
- CPAP/BiPAP
- ECMO (a machine that supplies oxygen to the blood when it circulates outside the body)
- None of the above
- Other

Please specify treatment: *Required

b) Did you require treatment in an Intensive Care Unit (ICU)? *Required

- No
- Yes
- Not Sure

How many days were you in the ICU? *Required

- 1 day
- 2 days
- 3 days
- 4 or more days
- Not Sure

c) What was the TOTAL DURATION of your hospitalization? *Required

- Less than 3 days
- 3-5 days
- 6-9 days
- 10 or more days
- Not Sure

d) Are you now out of the hospital? *Required

- No
- Yes

Where were you discharged to from the hospital? *Required [Only shows if "Yes" is selected for Q7d and answer to Q1 was NOT "Rehabilitation..."]

- [q1_live_where]
- Rehabilitation facility or skilled nursing facility
- Other

e) Would you be willing to sign and return a medical record release form to allow us to request medical records from facilities involved with your COVID-19 hospitalization? This is optional and does not impact participation in the study.

- No
- Yes

We will send this medical record request form to you by mail as soon as possible, thank you. Please continue to next page. [Only shows if "Yes" is selected for Q7e]
## MOBILITY AND OUTCOMES

8) CURRENTLY, do you regularly use a cane, walker, or wheelchair to get about?  
   - [ ] No  
   - [ ] Yes

9) In general, do you have any health problems that require you to limit your activities?  
   - [ ] No  
   - [ ] Yes

10) OVER THE PAST MONTH, how would you describe your level of physical activity or exercise, compared to your average physical activity level before the COVID-19 pandemic began?  
    - [ ] Much less  
    - [ ] Somewhat less  
    - [ ] About the same  
    - [ ] Somewhat more  
    - [ ] Much more
11) Have you EVER been diagnosed with any of the following conditions?
*Please be sure to repeat your reports when you receive your next usual questionnaire for \[dpm\_study\] within the next year*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Required</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Pneumonia</td>
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<tr>
<td>When were you diagnosed? *Required</td>
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<tr>
<td>Which month? *Required</td>
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<tr>
<td>b) Influenza (flu)</td>
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<td>When were you diagnosed? *Required</td>
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<tr>
<td>Which month? *Required</td>
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<tr>
<td>c) Chronic obstructive pulmonary disease (COPD) *Required</td>
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<tr>
<td>When were you diagnosed? *Required</td>
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<tr>
<td>Which month? *Required</td>
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<td>d) Asthma</td>
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<td>When were you diagnosed? *Required</td>
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<tr>
<td>Which month? *Required</td>
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<tr>
<td>e) Other lung disease (not including cancer) *Required</td>
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<tr>
<td>When were you diagnosed? *Required</td>
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</table>

[Sub-questions for Questions 11a-11r: "When were you Dx?" only shows if "Yes" is selected; "Which month?" only shows if "After January 1, 2020" is selected]
Which month? *Required
○ January 2020
○ February 2020
○ March 2020
○ April 2020
○ May 2020
○ Not Sure

f) Melanoma *Required
○ No  ○ Yes

When were you diagnosed? *Required
○ Before January 1, 2020
○ After January 1, 2020

Which month? *Required
○ January 2020
○ February 2020
○ March 2020
○ April 2020
○ May 2020
○ Not Sure

g) Non-melanoma skin cancer *Required
○ No  ○ Yes

Which type? *Required
○ Squamous cell
○ Basal cell
○ Not Sure

When were you diagnosed? *Required
○ Before January 1, 2020
○ After January 1, 2020

Which month? *Required
○ January 2020
○ February 2020
○ March 2020
○ April 2020
○ May 2020
○ Not Sure

h) Cancer (not including skin cancer) *Required
○ No  ○ Yes

Please specify site:

When were you diagnosed? *Required
○ Before January 1, 2020
○ After January 1, 2020

Which month? *Required
○ January 2020
○ February 2020
○ March 2020
○ April 2020
○ May 2020
○ Not Sure

i) Heart attack or myocardial infarction *Required
○ No  ○ Yes

When were you diagnosed? *Required
○ Before January 1, 2020
○ After January 1, 2020
<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
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</thead>
<tbody>
<tr>
<td>j) Coronary artery bypass surgery *Required</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>When were you diagnosed? *Required</td>
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<td>After January 1, 2020</td>
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<td>k) Coronary angioplasty or stent (balloon used to unblock an artery) *Required</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>When were you diagnosed? *Required</td>
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<td>After January 1, 2020</td>
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<td>l) Heart failure (congestive heart failure) *Required</td>
<td>No</td>
<td>Yes</td>
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<td>Were you hospitalized? *Required</td>
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<td>m) Stroke *Required</td>
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<td>n) Hypertension (high blood pressure)</td>
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<td>Required</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Which month?</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o) Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When were you diagnosed?</td>
<td>Required</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Which month?</td>
<td>Required</td>
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<tr>
<td>p) Kidney failure or dialysis</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>When were you diagnosed?</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Which month?</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q) Atrial fibrillation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When were you diagnosed?</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which month?</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r) Autoimmune diseases (rheumatoid arthritis, lupus, Crohn’s disease, psoriasis)</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When were you diagnosed?</td>
<td>Required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Required fields indicate that additional information is necessary for data completeness.
<table>
<thead>
<tr>
<th>Which month?</th>
<th>*Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>- January 2020</td>
<td></td>
</tr>
<tr>
<td>- February 2020</td>
<td></td>
</tr>
<tr>
<td>- March 2020</td>
<td></td>
</tr>
<tr>
<td>- April 2020</td>
<td></td>
</tr>
<tr>
<td>- May 2020</td>
<td></td>
</tr>
<tr>
<td>- Not Sure</td>
<td></td>
</tr>
</tbody>
</table>
### MEDICATIONS

12) Are you CURRENTLY taking any medications for high blood pressure?
- [ ] No
- [ ] Yes
- [ ] Not Sure

Which high blood pressure medications are you taking? Mark all that apply. [Only shows if "Yes" is selected in Question 12]
- [ ] Beta-blockers (Examples: atenolol, metoprolol, Carvedilol)
- [ ] Calcium channel blockers (Examples: amlodipine, diltiazem)
- [ ] Thiazide diuretics (Examples: hydrochlorothiazide, chlorthalidone, Moduretic, Dyazide, indapamide)
- [ ] Loop diuretics (Examples: furosemide, Lasix, torsemide, Bumex, ethacrynic acid)
- [ ] ACE-inhibitors (Examples: lisinopril, enalapril, ramipril, captopril, benazepril)
- [ ] Angiotensin receptor blockers (Examples: valsartan, irbesartan, Entresto, losartan, candesartan, olmesartan)
- [ ] Aldosterone receptor blockers (Examples: spironolactone, eplerenone)
- [ ] Alpha-blockers (Examples: terazosin, doxazosin)
- [ ] None of these medications

13) Are you CURRENTLY taking any medications for diabetes?
- [ ] No
- [ ] Yes
- [ ] Not Sure

Which diabetes medications are you taking? Mark all that apply. [Only shows if "Yes" is selected in Question 13]
- [ ] Insulin injections
- [ ] SGLT2 inhibitors (Jardiance, Invokana, Dapagliflozin)
- [ ] Glucophage (metformin)
- [ ] Non-insulin injections/GLP1 agonists (Examples: exenatide, Byetta, Ozempic, Victoza, Trulicity)
- [ ] Sulfonylurea (Examples: Glucotrol (glipizide), glimepiride, chlorpropamide)
- [ ] Other oral drugs (Examples: Avandia, Prandin, Januvia, Starlix, Actos)
- [ ] None of these medications
### 14) Are you CURRENTLY taking any of the following:

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Currently Taking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>statin drugs</td>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>Non-statin drugs</td>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>Antiplatelet medication</td>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>Anti-coagulant drugs</td>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>Immunosuppressant medications</td>
<td>[ ] No [ ] Yes</td>
</tr>
<tr>
<td>Over-the-counter medications</td>
<td>[ ] No [ ] Yes</td>
</tr>
</tbody>
</table>

#### Statin drugs
- [ ] Lipitor
- [ ] Zocor
- [ ] Mevacor
- [ ] Pravachol
- [ ] Crestor

#### Non-statin drugs
- [ ] niacin
- [ ] Lopid
- [ ] Questran
- [ ] Colestid
- [ ] Zetia
- [ ] Praluent
- [ ] Repatha

#### Antiplatelet medication
- [ ] clopidogrel
- [ ] Plavix
- [ ] prasugrel
- [ ] Effient
- [ ] ticagrelor
- [ ] Brilinta
- [ ] Zontivity

#### Anti-coagulant drugs
- [ ] warfarin
- [ ] Coumadin
- [ ] heparin
- [ ] dabigatran
- [ ] Pradaxa
- [ ] rivaroxaban
- [ ] Xarelto
- [ ] Savaysa
- [ ] Eliquis
- [ ] Lovenox

#### Antibiotics
- [ ] Azithromycin
- [ ] Other antibiotics

#### Immunosuppressant medications
- [ ] Corticosteroids or prednisone
- [ ] Methotrexate
- [ ] IL-6 inhibitors (Actemra, Sylvant)
- [ ] TNF blockers (Enbrel, Remicade, Humira)
- [ ] Other biologic agents (Rituxan, Orencia)
- [ ] Chloroquine or hydroxychloroquine
<table>
<thead>
<tr>
<th></th>
<th>m) Tylenol (acetaminophen)</th>
<th>n) Aspirin</th>
<th>o) Ibuprofen</th>
<th>p) Naproxen</th>
<th>q) Nurofen</th>
<th>r) Diclofenac</th>
<th>s) Other Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (Examples: Alka Seltzer, Excedrin, Celebrex)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Yes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
15) How do you feel physically right now?

- I feel physically normal or in my usual state of health
- I’m not feeling quite right compared to my usual health

16) Since January 1, 2020, have any of the following IN-PERSON, IN-CLINIC appointments for your regular care been cancelled or missed? ["Did you have a telehealth..." sub-question only shows if "Yes" is selected]

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual health checkup</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Primary care or general internist</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Oncologist</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Elective procedures</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Other</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

17) We would like to know how good or bad your health is TODAY. The scale below is numbered from 0 (the worst health you can imagine) to 10 (the best health you can imagine).

○ 0    ○ 1    ○ 2    ○ 3    ○ 4    ○ 5    ○ 6    ○ 7    ○ 8    ○ 9    ○ 10

18) What is your blood type?

- A
- B
- AB
- O
- Not Sure
19) What is your Rh Factor?

- Negative
- Positive
- Not Sure
20) Physical and Emotional Well-Being

a) How concerned are you about the COVID-19 pandemic?

- Not at all concerned
- Somewhat concerned
- Very concerned

b) What types of social or physical distancing steps are you taking? Mark all that apply.
By social or physical distancing, we mean steps you are taking to reducing amount of close physical contact you have with other people.

- Fewer social gatherings
- Avoid shopping
- Avoid public spaces like restaurants and theaters
- Avoid interactions with friends
- Avoid interactions with family
- Isolation from person(s) that live in your house
- Less physical activity or exercise
- I am not taking any social distancing steps
- Other

Please specify: [Only shows if "Other" is selected in 20b]

______________________________

c) Compared to the months before the COVID-19 pandemic began, how has the frequency of your communication with close friends and family changed?

- I communicate with them more frequently than before
- I communicate with them about the same as before
- I communicate with them far less often than before

d) How are you continuing to stay in touch with others? Mark all that apply.

- Speaking in person
- With phone calls
- With video calls
- By email
- By social media
- By postal mail
- Other

Please specify: [Only shows if "Other" is selected in 20d]

______________________________

e) How often are you communicating with others?

- Every day
- Several times per week
- 1-2 times per week
- Once per week
- Rarely or never
f) Who is providing you with social support during the outbreak? Mark all that apply.

- Someone I live with
- Friend or family who comes by my house
- Friend or family whom I talk with on the phone (or video chat)
- I do not have support
- Other

Please specify: [Only shows if "Other" is selected in 20f]

________________________


g) How much difficulty do you have obtaining the food that you need because of the COVID-19 pandemic or social distancing rules?

- No difficulty
- Some difficulty
- Much difficulty
- Unable to obtain or very difficult

h) How much difficulty do you have obtaining the medicine that you need because of the COVID-19 pandemic or social distancing rules?

- No difficulty
- Some difficulty
- Much difficulty
- Unable to obtain or very difficult

i) How much difficulty do you have with getting routine medical care that you need because of the COVID-19 pandemic or social distancing rules?

- No difficulty
- Some difficulty
- Much difficulty
- Unable to obtain or very difficult

j) How much has your sleep been interrupted or disturbed because of concern about the outbreak?

- Hardly ever
- Some of the time
- Often

k) How often do you feel that you lack companionship?

- Hardly ever
- Some of the time
- Often

l) How often do you feel left out?

- Hardly ever
- Some of the time
- Often

m) How often do you feel isolated from others?

- Hardly ever
- Some of the time
- Often

n) Over the PAST 2 WEEKS, how often have you been bothered by any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21) Did you get a flu vaccination after August 2019?</td>
<td>No, Yes, Not Sure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22) Do you currently smoke cigarettes?</td>
<td>No, Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On average, how many cigarettes per day do you smoke?</td>
<td>Less than 5, 5-14, 15-24, 25-34, 35-44, 45 or more, Not a current smoker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23) Do you vape or use electronic cigarettes (e-cigs)?</td>
<td>No, Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
24) Since January 1, 2020, for each beverage listed, fill in the circle indicating how often on average you have used the amount specified.

<table>
<thead>
<tr>
<th>Beverage</th>
<th>Never, or less than once per month</th>
<th>1-3 per month</th>
<th>1 per week</th>
<th>2-4 per week</th>
<th>5-6 per week</th>
<th>1 per day</th>
<th>2-3 per day</th>
<th>4-5 per day</th>
<th>6+ per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer (1 glass, bottle, can)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Red wine (5 oz glass)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>White wine (5 oz glass)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Liquor, e.g., whiskey, gin, vodka (1 drink or shot)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
</tbody>
</table>

Please do not include the COSMOS study pills for this question. [Only shows for COSMOS participants]

25) Are you CURRENTLY taking a multivitamin (Examples: Centrum, One-A-Day, PreserVision)?

- No
- Yes

Please do not include the COSMOS study pills for this question. [Only shows for COSMOS participants]

26) NOT including your diet, how much TOTAL vitamin D do you take each day from nutritional supplements such as single tablets of vitamin D, multi-vitamins, calcium supplements (Calcium+D) or drugs that may include vitamin D (Example: Fosamix+D)? Referring to package labels, please add up ALL your non-diet sources of vitamin D.

- None
- 0-400 IU per day
- 401-800 IU per day
- 801-1000 IU per day
- 1001-2000 IU per day
- 2001-3000 IU per day
- 3001-4000 IU per day
- Greater than 4000 IU per day
- Large dose weekly or monthly
- Don’t know

27) Are you CURRENTLY taking any of the following individual supplements? Please do not report the contents from multivitamins.

Vitamin C

- No
- Yes

How much?

- Less than 101 mg per day
- 101-500 mg per day
- 501-1000 mg per day
- 1001-2000 mg per day
- Greater than 2000 mg per day
- Don’t know

Zinc

- No
- Yes

How much?

- Less than 25 mg per day
- 25-74 mg per day
- 75-100 mg per day
- Greater than 101 mg per day
- Don’t know
28) Are there other individual supplements that you CURRENTLY take on a regular basis? Mark all that apply.

- B-complex
- Beta-carotene
- Calcium
- Choline
- Chromium
- Coenzyme Q10
- Cod liver oil
- Flax seed
- Flax seed oil
- Fish oil
- Folic acid
- Iron
- Lecithin
- Lycopene
- Magnesium
- Metamucil/Citrucel
- Niacin
- Potassium
- Selenium
- Vitamin A
- Vitamin B-6
- Vitamin B-12
- Vitamin E
- Vitamin K
- I don't take other supplements on a regular basis
- Other

Please specify: [Only shows if "Other" is selected in Question 28]

__________________________________

29) How much do you currently weigh without your shoes on?

__________________________________
(Pounds)

30) Optional: Would you be willing to provide a blood or saliva sample by mail on your own (e.g. with a fingerprick or simple collection device) to gather additional important information related to the COVID-19 pandemic?

(You can still take part in this important sub-study and the overall [dpm_study] study if you prefer not to provide a sample.)

- No
- Yes
- Not Sure

Please indicate who completed this survey.

- Study participant
- Spouse or family member on behalf of study participant