



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.



## **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](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](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>.]
- ABCD COVID-19 Impact Measure - Parent [Available from [https://www.phenxtoolkit.org/toolkit\\_content/PDF/UCSD\\_ABCD\\_Parent.pdf](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, 3<sup>rd</sup> 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](https://www.rand.org/health-care/surveys_tools/mos/social-support/survey-instrument.html).]
- Andresen EM, Malmgren JA, Carter WB, Patrick DL. Screening for depression in well older adults: evaluation of a short form of the CES-D (Center for Epidemiologic Studies Depression Scale). Am J Prev Med. 1994;10(2):77-84.
- Pilkonis PA, Choi SW, Reise SP, Stover AM, Riley WT, Cella D, et al. Item banks for measuring emotional distress from the Patient-Reported Outcomes Measurement Information System (PROMIS(R)): depression, anxiety, and anger. Assessment. 2011;18(3):263-83.
- Smith BW, Dalen J, Wiggins K, Tooley E, Christopher P, Bernard J. The brief resilience scale: assessing the ability to bounce back. Int J Behav Med. 2008;15(3):194-200.
- Russell DW. UCLA Loneliness Scale (Version 3): reliability, validity, and factor structure. J Pers Assess. 1996;66(1):20-40.
- Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav. 1983;24(4):385-96.
- COVID-19 Attitudes and Beliefs (Gadoth A, Halbrook M, et al. Cross-sectional Assessment of COVID-19 Vaccine Acceptance Among Health Care Workers in Los Angeles. Ann Intern Med. 9 February 2021. <https://doi.org/10.7326/M20-7580>. Investigators using these items should contact PI Anne Rimoin, [arimoin@ucla.edu](mailto:arimoin@ucla.edu)).





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 →
- No

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

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

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



**HEALTHCARE PROVIDER**

Since the last COVID questionnaire, has a healthcare provider ever told you that you had COVID-19?

- 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 COVID19?

- 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:

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**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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
A breathing tube or ventilator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
"Intensive care unit" or ICU monitoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Dialysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
A breathing tube or ventilator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
"Intensive care unit" or ICU monitoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Dialysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

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 your 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: How many days did you have the symptom?	If yes: Do you still have the symptom?
Fever	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Shortness of breath (trouble breathing)	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Cough	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Chest pain	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Abdominal pain	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Nausea	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Vomiting	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Diarrhea	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Body or muscle aches	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Weakness or fatigue	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Runny or dripping nose	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Chills	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Headache	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Sore throat	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Stuffy nose (nasal congestion)	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> 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.

<b>Symptom</b>	<b>Yes</b>	<b>If yes: How many days did you have the symptom?</b>	<b>If yes: Do you still have the symptom?</b>
New loss of taste or smell	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Confusion	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Trouble sleeping	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Conjunctivitis	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Skin changes	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> No
Other: _____	<input type="checkbox"/>		<input type="radio"/> Yes <input type="radio"/> 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?

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**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
- No

—————→

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

- Yes
- No

—————→

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

- Yes
- 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	<input type="radio"/>	<input type="radio"/>
The rushed/ fast-tracked research and development timeline	<input type="radio"/>	<input type="radio"/>
The frequently changing science of COVID-19	<input type="radio"/>	<input type="radio"/>
Actions and opinions of my friends and family regarding the vaccine	<input type="radio"/>	<input type="radio"/>
My trust in scientists	<input type="radio"/>	<input type="radio"/>
My own reading and research on coronavirus (COVID-19) vaccines	<input type="radio"/>	<input type="radio"/>
The country in which a vaccine is manufactured	<input type="radio"/>	<input type="radio"/>
The potential cost of a coronavirus (COVID-19) vaccine	<input type="radio"/>	<input type="radio"/>
Other (please specify): _____	<input type="radio"/>	<input type="radio"/>



	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 “Pevnar”)?

- 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	<input type="radio"/>	<input type="radio"/>
Overall, vaccines are safe	<input type="radio"/>	<input type="radio"/>
Overall, vaccines are effective	<input type="radio"/>	<input type="radio"/>
The information I receive about vaccines from public health authorities/my healthcare provider is reliable and trustworthy	<input type="radio"/>	<input type="radio"/>
I am concerned about serious adverse (bad) effects of vaccines	<input type="radio"/>	<input type="radio"/>



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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The flu vaccine is safe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The flu vaccine is effective	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The flu vaccine is convenient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The flu vaccine is affordable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am required to get a flu vaccine for my job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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?
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?

Yes  No  Not Applicable



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?

Yes  No  Not Applicable

Did you or any member of your household lose other sources of financial support, like food stamps?

Yes  No  Not Applicable

Did you lose your housing, or become homeless?

Yes  No  Not Applicable

Did you have a change in your health insurance coverage?

Yes  No  Not Applicable



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?

Yes  No  Not Applicable



**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding contact with people outside of my home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Washing hands and/or using sanitizer frequently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying at least 6 feet away from others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding large gatherings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding eating indoors at restaurants/bars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancelled planned travel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wearing a face mask	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not shaking hands or touching people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not going to work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wiping down surfaces with disinfectant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Vigorous activities (like running)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Watching shows or movies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If doing this activity now, how much?
Drinking alcoholic beverages	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	____ drinks/week
Smoking cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	____ cigarettes/day
E-cigarettes (vaping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	____ e-cigarettes/day
Using medical or recreational marijuana/cannabis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	____ 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you wake up several times at night?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you wake up earlier than you planned to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have trouble falling back asleep after you woke up too early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Very sound or restful	Sound or restful	Average quality	Restless	Very restless
Overall, was your typical night's sleep over the past 4 weeks...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not "get going."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>				
I felt uneasy	<input type="radio"/>				
I found it hard to focus on anything other than my anxiety	<input type="radio"/>				
I felt fatigued	<input type="radio"/>				
I had trouble starting things because I was tired	<input type="radio"/>				
How run down did you feel on average?	<input type="radio"/>				
How fatigued were you on average?	<input type="radio"/>				



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	<input type="radio"/>				

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel left out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel isolated from others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?	<input type="radio"/>				
In the last month, how often have you felt confident in your ability to handle your personal problems?	<input type="radio"/>				
In the last month, how often have you felt that things were going your way?	<input type="radio"/>				
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>				

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

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**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have noticed increased conflict in our family since our area started worrying about coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think all of this worry about coronavirus is blown out of proportion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think it is likely that I will get coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think it is likely I will be hospitalized or die from the coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think it is likely that someone very close to me will get coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think it is likely that someone very close to me will be hospitalized or die from the coronavirus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>