HCHS/SOL
COVID-19 Questionnaire Wave 2 (CVEB)

ID NUMBER:									FORM CODE: CVEB VERSION: 2, 12/15/2021	Contact Occasion	0	3	Occurrence	0	1

Instructions: *This survey should be administered to all HCHS/SOL eligible participants. Data collection can occur as part of an AFU call (immediately after) or as a separate call. Responses on this questionnaire can be supplied by a designated AFU respondent. The Completion Date is the day the interview was attempted or the questionnaire was completed. Use the CDART field status to code 'Don't know/refused, Missing, etc.' for those questions that do not list these as an option.*

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

0c. Did the participant report a COVID-19 diagnosis or is there a record of a COVID-19 hospitalization on the Wave 1 CVE form? **[pre-filled by CDART]**

No 0 ☐
Yes 1 ☐

0d. Next, I would like to ask you about COVID-19 related experiences. Responses to this survey will contribute to a better understanding of COVID-19 and the way it affects people like you. Is that okay?

No 0 ☐ **[Go to Question 0e]**
Yes 1 ☐ **[If 0c=Yes, Skip to Q1; If 0c=No, Skip to Q2]**

0e. Can I call you back at a convenient time to ask these questions?

No 0 ☐ **[END FORM]**
Yes 1 ☐

0f. When would it be convenient to call back? ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

0f1. Time to call back: ☐☐:☐☐ **[24-hr format]**

0g. Staff notes: _____

COVID-19 SELF-REPORT

0h. Date of most recent COVID call or C4R start date: ☐☐/☐☐/☐☐☐☐ **[pre-filled by CDART]**

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1. During our last call on _____, a positive COVID-19 diagnosis was reported. What was the date of your diagnosis?

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

2. Since _____, have you 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). Please do not include any COVID-19 testing done by HCHS/SOL (i.e., Dried blood spot testing).

0 ☐ No **[Go to Question 8]**
1 ☐ Yes
2 ☐ Unsure **[Go to Question 8]**

3. What type of test was it? (Select all that apply)

a. Nose (“nasal”, “nasopharyngeal”) swab 0 ☐ No 1 ☐ Yes
b. Throat swab 0 ☐ No 1 ☐ Yes
c. Spit (“saliva”) test 0 ☐ No 1 ☐ Yes
d. Blood test 0 ☐ No 1 ☐ Yes
e. Other 0 ☐ No 1 ☐ Yes

e.1. Please specify Other: _____

4. Did you have a positive test that showed you had COVID-19? Please include all types of tests.

0 ☐ No **[Go to Question 6]**
1 ☐ Yes **[Go to Question 5]**
2 ☐ Unsure **[Go to Question 8]**

5. Since _____, when was it that you <u>first had a test</u> that showed you had COVID-19?

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy) **[If Q4=Yes, Answer then Skip to Question 12]**

6. Do you think that you may have had COVID-19 at any time between _____ and now, even though you had a negative COVID-19 test?

0 ☐ No **[Go to Question 25]**

1 ☐ Yes, definitely
2 ☐ Yes, I think so
3 ☐ Maybe

7. When was it that <u>you think you first had</u> COVID-19, during that time period between _____ and now? **[Answer then Skip to Question 12]**

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

8. Do you think that you may have had COVID-19 at any time between _____ and now, even though you <u>did not</u> have a positive COVID-19 test?

0 ☐ No **[Go to Question 25]**
1 ☐ Yes, definitely
2 ☐ Yes, I think so
3 ☐ Maybe

9. Why did you not get tested at that time? (Select all that apply)

a. I didn't know how/where to get tested 0 ☐ No 1 ☐ Yes
b. It was hard to get tested (e.g., long lines) 0 ☐ No 1 ☐ Yes
c. I was afraid to get tested 0 ☐ No 1 ☐ Yes
d. I didn't think I needed to be tested 0 ☐ No 1 ☐ Yes
e. I was worried about the cost 0 ☐ No 1 ☐ Yes
f. I was worried about the consequences of being diagnosed with COVID19 0 ☐ No 1 ☐ Yes
g. A healthcare provider told me that a test was not necessary 0 ☐ No 1 ☐ Yes

10. When was it that <u>you think you first had</u> COVID-19 during that time period between ___ and now?

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

Q11 – Part A

11. At that time, did you have any of the following? (Select all that apply)

a. Symptoms of COVID-19 (such as fever, cough, trouble breathing) 0 ☐ No 1 ☐ Yes
b. Contact with someone who had COVID-19 0 ☐ No 1 ☐ Yes
c. Other 0 ☐ No 1 ☐ Yes
c.1. Please specify Other: _____

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Q11 – Part B: COVID-19 RE-INFECTION

Questions 11d-11j are applicable only to those with a COVID-19 diagnosis reported between Wave 1 date and now (responded "Yes" to question 4, 6, or 8.)

"You have reported that you know or think that you were infected with COVID-19 in [FILL IN MONTH, YEAR FROM Q5, Q7, or Q10.] The following questions ask about possible re-infections you may have had since that time."

11d. Since the time you had COVID-19 on _____, 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 COVID-19?

0 ☐ No **[Go to Question 12]**
1 ☐ Yes

11e. When do you know or think that you were first **re-infected** with COVID-19, since ___?

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

11f. At that time, did you have any of the following? (Check all that apply)

11f1. Another test that showed that you had COVID-19 0 ☐ No 1 ☐ Yes
11f2. Symptoms of COVID-19 (such as fever, cough, trouble breathing) 0 ☐ No 1 ☐ Yes
11f3. Contact with someone who had COVID-19 0 ☐ No 1 ☐ Yes
11f4. Other 0 ☐ No 1 ☐ Yes
11f5. Please specify Other: _____

11g. This time, when you were re-infected, how did your symptoms compare to your first infection with COVID-19?

1 ☐ Worse than the first infection
2 ☐ About the same as the first infection
3 ☐ Better than the first infection
4 ☐ I had no symptoms

11h. Have you had another COVID-19 re-infection since then?

0 ☐ No → **Go to 11j**
1 ☐ Yes
9 ☐ Do not know → **Go to 11j**

11i. If Yes, when do you know or think that you were reinfected for a second time?

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☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

11j. "Before we go on to the next section, I would like to review what you told me. You were first infected with Covid -19 on _____ Then, you were infected again on _____, [another time on _____,] [and another time on _____]. Is that correct?"

0 ☐ No → **Correct answers**
1 ☐ Yes

[Do not move on to next section until answers to Q11d-Q11i are confirmed.]

COVID-19 HOSPITALIZATION

Time frame for Questions 12-20 is since the date of the most recent COVID call, if applicable. If participant did not complete a Wave 1 COVID-19 Interview, time frame is from 3/1/2020 to now. See date in Q0h.

"I now want to ask you about COVID-19 hospitalizations that you may have had recently."

12. Since _____, have you had an overnight stay in a hospital for any illness related to COVID-19?

0 ☐ No **[Go to Question 19]**
1 ☐ Yes
2 ☐ Unsure **[Go to Question 19]**

13. How many times have you been admitted to the hospital for COVID-19 or complications resulting from COVID-19? ☐☐

14. When was the first time that you were hospitalized for COVID-19 or complications resulting from COVID-19?

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

15. Which hospital were you admitted to?

a. Hospital name: _____
b. City: _____
c. State/Country: _____

16. How many nights did you spend in the hospital during your first COVID-19 related hospitalization?

☐☐☐

17. While in the hospital, did you have any of the following:

a. Oxygen (by mask or nose)

0 ☐ No
1 ☐ Yes
2 ☐ Do not know

a.1. If Yes, for how many days? ☐☐☐

b. A breathing tube or ventilator

0 ☐ No
1 ☐ Yes
2 ☐ Do not know

b.1. If Yes, for how many days? ☐☐☐

c. "Intensive care unit" or ICU monitoring

0 ☐ No
1 ☐ Yes
2 ☐ Do not know

c.1. If Yes, for how many days? ☐☐☐

d. Dialysis

0 ☐ No
1 ☐ Yes
2 ☐ Do not know

d.1. If Yes, for how many days? ☐☐☐

18. After this hospitalization, did you…?

1 ☐ Return home
2 ☐ Go to a nursing home or rehabilitation facility
3 ☐ Go to live with a family member or friend
4 ☐ Other

18.a. Other, specify: _____

COVID-19 SYMPTOMS

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"Now I would like to ask you about symptoms you may have had when you had COVID-19 or thought you had COVID-19."

19. When you knew or thought that you had COVID-19, did you have any symptoms?

0 ☐ No **[Go to Question 21]**
1 ☐ Yes
2 ☐ Unsure **[Go to Question 21]**

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

1 ☐ Not at all
2 ☐ A little bit
3 ☐ Somewhat
4 ☐ Quite a bit
5 ☐ Very much
6 ☐ I do not remember

COVID-19 RECOVERY

21. Following your most recent COVID-19 infection, would you say that you are now completely recovered from COVID-19?

0 ☐ No **[Go to Question 24]**
1 ☐ Yes
2 ☐ Unsure **[Go to Question 24]**

22. How long did it take for you to recover? a.☐☐ months b.☐☐ days

23. At this time, do you have any of the following symptoms? (Select all that apply)

Symptom:

a. Problems with your memory 0 ☐ No 1 ☐ Yes
b. Problems with paying attention 0 ☐ No 1 ☐ Yes
c. Problems with your appetite 0 ☐ No 1 ☐ Yes
d. Problems with feeling lightheaded 0 ☐ No 1 ☐ Yes
e. Trouble sleeping 0 ☐ No 1 ☐ Yes
f. Periods of racing heart rate 0 ☐ No 1 ☐ Yes

g. Inability to exercise at pre-COVID level 0 ☐ No 1 ☐ Yes
h. Inability to return to work or school (if you were working or in school pre-COVID) 0 ☐ No 1 ☐ Yes
i. Inability to return to your usual pre-COVID activities 0 ☐ No 1 ☐ Yes
j. Feeling weak, tired and/or sick 24-48 hours after physical activity 0 ☐ No 1 ☐ Yes
k. Other 0 ☐ No 1 ☐ Yes

k.1.If Other, specify: _____

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

1 ☐ Not at all worried
2 ☐ A little worried
3 ☐ Very worried

COVID-19 VACCINE

25. Have you received a vaccine for COVID-19?

0 ☐ No **[END FORM]**
1 ☐ Yes
2 ☐ Unsure **[END FORM]**

26. Which vaccine did you receive?

1☐ Moderna
2☐ Pfizer
3☐ AstraZeneca
4☐ Janssen or Johnson & Johnson / J&J
5☐ Don't know
6☐ Other
26a. If Other, please specify: _____

27. How many doses did you receive?

1☐ One
2☐ One, but plan to get a second one
3☐ Two
4☐ Three or more

28. When did you receive your most recent dose of the vaccine?

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