



HCHS/SOL- COVID19 Questionnaire

(CVE) (minor corrections 6/3/2020)

ID NUMBER:

FORM CODE: CVE
VERSION: 1, 5/4/2020

Contact Occasion

0 3

Occurrence

0 1

ADMINISTRATIVE INFORMATION

0a. Completion Date: //

0b. Staff ID:

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. Refer to QxQ for telephone script to be used for separate check-in call, or with AFU call. Responses on this questionnaire can be supplied by a designated AFU respondent. Enter the answer given by the participant or respondent for each response. Use the CDART field status to code 'Don't know/refused, Missing, etc.' for those questions that do not list these as an option.

0c. Next I would like to ask you about COVID-19 Related experiences. Is that okay?

No, participant refused 0

Yes, participant agreed 1 **[Go to Q1]**

No, respondent refused to answer 2

Yes, respondent agreed 3 **[Go to Q1]**

0c1. May I call you back at a convenient time to ask these questions?

No 0 **[Go to Closing section B, Question 8]**

Yes 1

0c2. When would it be convenient call back? Date: //

0c3. Time: : **[24-hr format]**

“Thank you. I will call again.” [Go to Closing section B, Question 8]

A. COVID19 Questions

1. Have you had COVID-19, or the illness caused by the novel coronavirus?

No 0

Yes, definitely 1

Yes, I think so 2

Maybe 3

2. Has a healthcare provider ever told you that you had COVID-19?

No 0 **[Go to Question 3]**

Yes, definitely 1

Yes, probably or suspected 2

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“Please provide the contact information of the doctor who told you that you had COVID-19.”

2a. Doctor’s name: _____

2b. Clinic or Institution Name: _____

2c. Address: _____

2d. City: _____

[Outside the US, enter City and Country]

2e. State:

[Ask Q2f only if Q1 OR Q2 is recorded as ‘Yes, definitely’]

2f. Have you recovered to your usual state of health from your COVID-19 illness?

No 0 **[Go to Question 3]**

Yes 1

2g. How long did it take for you to recover? days

3. **Since January 1, 2020**, have you had a cold or flu-like illness?

No 0 **[Go to Question 4]**

Yes 1

3a. What was the approximate date of this illness? / /

3b. Approximately how many days did the symptoms last? days

4. Have you been tested for coronavirus or COVID-19?

No 0 **[Go to Question 5]**

Yes 1

Unsure 2 **[Go to Question 5]**

4a. How many times have you been tested? times

“Can you provide details regarding your first COVID-19 test?”

4b. What was the date of your first COVID-19 test? / /

4c. Reasons for first COVID-19 test: **No Yes**

4c1. I had symptoms of COVID-19 0 1

4c2. Someone I know had symptoms of COVID-19 0 1

4c3. A doctor told me to be tested for COVID-19 0 1

4c4. I was worried about COVID-19 0 1

4c5. Other 0 1

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4c5a. If other, please specify: _____

4d. Type of test for first COVID-19 test:

- Nasopharyngeal swab 1
- Blood test 2
- Saliva test 3
- Other 4

4d1. If other, please specify: _____

4e. What was the result of your first COVID-19 test?

- Negative 0
- Positive 1 **[Go to Question 5]**
- Unsure 2

[Ask Q4f only if participant had more than one test done (Q4a> '1') AND (Q4e=0,2)]

4f. Did you ever have a positive COVID-19 test?

- No 0
- Yes 1

5. Have you ever had an overnight stay in a hospital for suspected or diagnosed COVID-19?

- No 0 **[Go to Question 6]**
- Yes 1

5a. How many nights were you in the hospital? nights

5a1. Date arrived at hospital: //

5a2. Date discharged from hospital: //

For ascertainment of medical records, can you please provide:

5b. Hospital Name: _____,

5b1. Hospital City: _____,

[Outside the US, enter City and Country]

5b2. Hospital state:

ID NUMBER:								
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“Next, I have some questions about others who might live with you.”

6. How many people live in your household (or the place you are residing)? **[Q6 ONLY, options 2-4, includes participant]**

- Live alone 1 **[Go to Question 7]**
- Two people 2
- Three people 3
- More than three people 4

6a. How many people in your household (or the place you are residing) **other than yourself** have been tested for COVID-19?

- None 0 **[Go to Question 7]**
- One person 1
- Two people 2
- Three people 3
- More than three people 4

6b. How many of the test results were positive?

- None 0 **[Go to Question 7]**
- One person 1
- Two people 2
- Three people 3
- More than three people 4

- | | No | Yes |
|--|--|----------------------------|
| 6c. Did you change your behavior at home? | 0 <input type="checkbox"/> [Go to Question 7] | 1 <input type="checkbox"/> |
| 6c1. Did you wear a mask at home? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 6c2. Did the infected person(s) wear a mask at home? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 6c3. Did the infected person(s) stay away from you? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

- | | No | Yes |
|---|--|----------------------------|
| 7. In your home, is there anyone who regularly goes outside (e.g., for work)? | 0 <input type="checkbox"/> [Go to Question 8] | 1 <input type="checkbox"/> |
| 7a. Are you able to stay 6 feet away? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

B. CLOSING

Thank you. We understand that this may be a difficult time for many HCHS/SOL participants.

8. Do you have any questions about COVID-19, or where you can go to get resources and support?

- No 0
- Yes 1 **[See FAQs]**

Okay. If you need any additional information, please give us a call. Thank you for your participation.