

Columbia COVID-19 Questionnaire - Patient Case Proband VERSION 2.3

COVID-19 infection is a major challenge around the world. You are participating in this research because you were infected or you may have been infected by the COVID-19 (SARS-COV2) virus. By answering these questions about your experience with the viral disease, you will be part of timely research to understand why some people get severe disease, whereas others get mild disease or none at all. This survey takes approximately 15 minutes to complete. We are working to gather this information quickly, share information without identifying who you are to researchers around the world, and learning quickly to help others. Surveys will be de-identified prior to research use. Contact information is for follow-up contact.

Name:

Email address:

Phone number:

Zip code:

Date of questionnaire (captured electronically)

1. Please select the most accurate choice describing your test for the coronavirus?

- Yes, by nasal swab, date of the test _____
- Yes, by serum antibody tests, date of the test _____
- I was not tested, but I had suspected COVID
- I was not tested and had no symptoms
- My test was negative, date of the test _____
- I don't know

2. How was your infection treated? (pick single response reflecting your most intensive level of care)

- My infection was managed at home
- I was seen in the clinic or screening tent, but I was sent home
- I was seen in the emergency room, but I was sent home
- I was admitted to the hospital
- I was in the intensive care unit

3. How long were you sick?

- First day of symptoms, date _____
- Last day of symptoms, date _____
- Do not know/ do not remember

4. Please describe your symptoms (check all that apply):

- cough, for how many days ____
- fever, for how many days __ , highest temperature _____
- shortness of breath, for how many days _____
- chest pain, for how many days _____
- night sweats, for how many days _____
- rash, for how many days _____
- fatigue
- headache
- muscle pain
- runny nose
- sore throat
- diarrhea
- nausea or vomiting
- abdominal pain
- foamy urine, for how many days _____
- red urine, for how many days _____
- partial or complete loss of smell, for how many days _____
- partial or complete loss of taste, for how many days _____
- loss of consciousness
- seizures

5. If you were hospitalized, did you have the following? (check all that apply)

- Oxygen supplementation through nasal cannula, for how many days _____
- Oxygen mask, BIPAP, or CPAP, for how many days _____
- Intubation with ventilator support, for how many days _____
- Kidney problems requiring dialysis of any kind, for how many days _____
- Heart problem requiring cardiac catheterization
- Liver problem or hepatitis
- Blood clots in legs or lungs
- Septic shock requiring blood pressure support with pressor infusions
- Other complications, please specify _____

6. Do you know if doctors used any of the following medications to treat your COVID-19 illness? (select all that apply):

- Tylenol (acetaminophen)
- NSAIDs (ibuprofen, aspirin, naproxen, celecoxib, diclofenac, indomethacin, piroxicam)
- Hydroxychloroquine (Plaquenil) or Chloroquine
- Azithromycin (Z-pack)
- Pepcid or Famotidine
- Corticosteroids (prednisone, methylprednisolone, dexamethasone, hydrocortisone)
- IL-6 pathway blockers (sarilumab, tocilizumab, siltuximab)
- JAK inhibitors (baricitinib, ruxolitinib, fedratinib, tofacitinib)
- Remdesivir (GS-5735) or another protease inhibitor
- Tamiflu (oseltamivir) or Xofluza (baloxavir marboxil)
- HIV medications [lopinavir/ritonavir, tenofovir (TDF, TAF)]
- Sofosbuvir
- Ribavirin
- Interferon Alpha
- Plasma therapy (antibodies from someone else)
- Bronchodilators (asthma like medications)
- Don't know

7. If you were treated with hydroxychloroquine (Plaquenil), please describe if you experienced the following? (select all that apply):

- Nausea or vomiting
- Red skin rash
- Severe necrotizing skin rash
- Headaches or migranes
- Vision problems or blindness
- Night sweats
- Insomnia
- Heart problems
- Abnormal heart beat, or arrythmia
- Ringing in my ears
- Tingling sensation
- Loss of sensation in hands or feet
- Seizures
- Loss of consciousness or passing out
- Hearing or seeing things that do not exist
- None of the above

8. Have you received a vaccination this year against the following? (check all that apply)

- Flu shot
- Pneumococcal vaccine or Pneumovax
- Tuberculosis (TB) vaccine (BCG) at any time in your life
- None of the above
- I don't know

9. How would you rate your general health status prior to the infection?

- Excellent
- Very Good
- Good

- Fair
- Poor

10. Have you ever had any of the following diseases diagnosed or treated? (check all that apply)

- Heart failure
- Heart attacks
- Atrial fibrillation, palpitations or abnormal heart rhythm
- Pacemaker implanted
- Arrhythmia or cardiac arrest
- Chronic kidney disease
- Protein in the urine
- Blood in the urine
- Kidney failure requiring dialysis
- Kidney failure requiring kidney transplant
- Liver disease or cirrhosis
- Liver failure requiring liver transplant
- Heart failure requiring heart transplant
- Asthma
- Obesity
- Sleep apnea
- Chronic obstructive pulmonary disease (COPD)
- High pressure in the lung (pulmonary hypertension)
- Another lung disorder, which one: _____
- Neurological disorder (e.g., ALS, Parkinson's, Huntington's)
- Dementia
- Cancer
- Osteoarthritis
- Rheumatoid arthritis
- Other type of inflammatory arthritis, specify _____
- Recurrent ear infections/sinusitis
- HIV
- Anemia
- Prior blood clots in legs or lungs
- Bone marrow recipient
- Thyroid Disease
- Lupus
- Multiple Sclerosis
- Ulcerative colitis
- Crohn's Disease
- Celiac Disease
- Periodic/Frequent fevers
- Immune deficiency
- Cold sores
- Herpes
- Warts
- Molluscum
- Shingles
- Eczema
- Recurrent bacterial infections
- Allergies
- Hives
- Hay Fever

11. Have you been diagnosed with diabetes?

- no
- no, high blood sugar
- yes, type 1 diabetes (treated with insulin)
- yes, type 2 diabetes (often treated with pills)
- yes, but I don't know the type
- yes, gestational diabetes

12. What drugs prescribed by a physician do you use for diabetes?

- no drugs
- insulin
- pills
- insulin and pills

13. Have you ever been diagnosed with hypertension or high blood pressure?

- no
- yes
- yes, but only during pregnancy

14. Have you ever used blood pressure medication?

- no
- yes, what medication? _____

15. Has a doctor ever told you that you had a (if yes indicate age):

- heart attack, age__
- stroke, age __
- head hemorrhage, age__
- coronary artery bypass surgery, age __
- cardiac catheterization or stent, age__

16. When did you last use the following medications? (please fill in your answer for each row).

	Today or Yesterday	2-7 days ago	1-4 weeks ago	1-12 months ago	Over a year ago	Never
Nonsteroidal anti-inflammatory agents or NSAIDS (aspirin, celecoxib, diclofenac, Cambia, Cataflam, Voltaren, diflunisal, etodolac, ibuprofen, Motrin, Advil, indomethacin, Indocin, ketoprofen, ketorolac, nambumetone, naproxen, Aleve, Anaprox, Naprelan, Naprosyn, oxaprozin, Daypro, piroxicam, Feldene, salsalate, Disalate, sulidnac, tolmetin)						
Acetaminophen, Tylenol, Daquil, Nyquil, Excedrin, Sinutab.						
Asthma Meds (bronchodilator Ventolin, albuterol)						
Oral or injected steroids (prednisone, methylprednisolone, dexamethasone, hydrocortisone)						
Inhaled corticosteroids (Advair, beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, or mometasone)						
Antihistamines (Benadryl, Clarithin, Zyrtec)						
Antibiotics						
Aspirin for the prevention of heart attack or stroke						
Antiplatelet medications other than aspirin (e.g. clopidogrel, Plavix, prasugrel, ticagrelor, cilostazol)						
Blood thinning medications (Eliquis, Xarelto, Coumadin, Warfarin or similar)						
ACE inhibitors for high blood pressure (Benazepril, Captopril, Fosinopril, Lisinpril, etc.)						
A statin to lower cholesterol (such as atorvastatin or simvastatin)						
Angiotensin Receptor Blockers for high blood pressure (Edarbi, Atacand, Eprosartan, Avapro, etc.)						
Tacrolimus						
Cyclosporine						
Azathioprine						
Cancer drugs or chemotherapy						
Mycophenolate						
Injections for immune condition such as Enbrel, humira, actemra, anakinra, Xolair, dupixent						
Infusion for immune condition such as infliximab (Remicade), rituximab, abatacept (Orencia), and belimumab (Benlysta)						
The thyroid medication levothyroxine						
Famotidine (Pepcid)						

Diabetic medication metformin						
The proton-pump inhibitor omeprazole						
A beta-blocker to lower blood pressure (metoprolol, atenolol, tramadol, ...)						
An anti-depressant or SSRI (sertraline, fluoxetine, citalopram, trazodone, escitalopram, ...)						
An opioid for pain relief (hydrocodone, ...)						
HIV medication (lopinavir/ritonavir, darunavir/ritonavir, tenofovir disoproxil fumarate (TDF), tenofovir alafenamide fumarate (TAF), and combination medications containing these agents)						

17. Prior to Covid19, when was the last time a doctor gave you antibiotics?

- In the last month
- In the last year
- Within the last 5 years
- Within the last 10 years
- Over 10 years ago
- Never

18. For what purpose, did the doctor give you antibiotics the last time you took antibiotics?

- respiratory infection (e.g. strep throat, sinusitis, bronchitis, pneumonia)
- gastroenteritis, which caused diarrhea and/or vomiting
- urinary tract infection
- infection of the skin or a wound infection
- other purpose
- I don't know
- I have never taken antibiotics

19. How long was your course of antibiotics?

- 3 days
- 7 days
- 14 days
- More than 14 days
- I don't know

20. How often do you usually get a cold?

- Never
- Once every 2 years
- Once a year
- Twice a year or more

21. What is your blood type?

- A
- B
- AB
- 0
- I don't know

- Rh-positive
- Rh-negative
- I don't know

22. Were you abroad just before getting sick / being exposed to or being suspected for COVID-19 infection

- no
- yes, country: _____ exact dates of travel: _____

23. How many people live with you in your apartment/house? Including yourself.

- (Fill in 0 if none are)
- ___ under 3 years old
 - ___ 3–6 years old
 - ___ 7–17 years old

- 18–64 years old
- 65–79 years old
- 80 years old or older

24. What type of household do you live in?

- Studio
- One bedroom apartment
- Two bedroom apartment
- Three bedroom (or more) apartment
- Townhouse
- Free-standing house
- Nursing home, or rehab facility
- Homeless
- Prefer not to answer

25. How many people in your household have been infected with or presumed to be infected with COVID-19?

_____people

26. Have any of your family members:

- been diagnosed with COVID-19? relationship: _____
- been suspected to have COVID-19? relationship: _____
- been hospitalized due to COVID-19? relationship: _____
- died due to COVID-19? relationship: _____

27. Do any of your family members have an immune deficiency or immune-related condition?

- yes
- no

28. What diseases run in your family?

- cancer, specify _____
- heart disease
- hypertension
- diabetes
- kidney disease, specify _____
- other, specify _____

29. In the 2 weeks prior to becoming ill, how often did you wear a face mask in public?

- never
- rarely
- usually
- always

30. In the 2 weeks prior to becoming ill, how often did the people you live with wear a face mask in public?

- never
- rarely
- usually
- always

31. In the 2 weeks prior to becoming ill, how often did you use hand sanitizer?

- never
- rarely
- usually
- always

32. In the 2 weeks prior to becoming ill, how often did the people you live with use hand sanitizer?

- never
- rarely
- usually
- always

- 33. In the 2 weeks prior to becoming ill, how often did you consciously attempt to socially distance from others?**
- never
 - rarely
 - usually
 - always
- 34. In the 2 weeks prior to becoming ill, how often did the people you live with consciously attempt to socially distance from others?**
- never
 - rarely
 - usually
 - always
- 35. In the 2 weeks prior to becoming ill, how often did you leave your apartment or house?**
- never
 - 3 to 4 times a week
 - daily
 - multiple times per day
- 36. Do any pets live in your household? If so, indicate which of the following:**
- dog
 - indoor cat
 - indoor/outdoor cat
 - other: _____
- 37. When was the last time you pet a dog or cat before you got sick?**
- One day
 - One week
 - One month
 - More than one month
 - Don't remember
- 38. In the two weeks prior to becoming ill, how did you purchase groceries?**
- delivery
 - online order/ in store pick up
 - went to store
 - did not shop
- 39. What transportation did you take in the two weeks prior to becoming ill? (check all that apply)**
- subway
 - bus
 - uber/lift/cab or similar
 - airplane
 - car
- 40. Were you able to telecommute to work in the two weeks prior to becoming ill?**
- yes
 - no
 - NA (lost job as part of COVID19)
 - NA (unemployed or retired prior to disease)
- 41. Thinking about members of your family living in this household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?**
- \$0 to \$9,999
 - \$10,000 to \$14,999
 - \$15,000 to \$19,999
 - \$20,000 to \$34,999
 - \$35,000 to \$49,999

- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 or more
- Don't know/Not sure
- Prefer not to answer

42. How do you normally pay for healthcare?

- Insurance from my work
- Insurance bought from 'Obamacare'
- Medicare
- Medicaid
- Indian Health Service
- VA
- uninsured
- Not sure/refused

43. What is the highest grade or level of schooling you completed?

- No formal schooling
- Less than 8 years
- 8 through 11 years
- 12 years or completed high school
- Post high school training other than college (vocational or technical)
- Some college
- College graduate
- Postgraduate
- Don't know/Not sure
- Prefer not to answer

44. Is there a place you USUALLY go to when you are sick, if so where?

- Clinic or health center
- Doctor's office or HMO
- Hospital Emergency room
- Hospital Outpatient department
- Some other place (for example, faith healer, botanica, acupuncture etc.)
- I don't go to one place
- Prefer not to answer

45. Did you have a routine health exam (check-up) in the last year?

- yes
- no
- not sure

46. How long does it take to travel to see a healthcare provider when sick?

- <10 minutes
- 10-30 minutes
- 30-60 minutes
- 1-2 hours
- >2 hours
- Don't know
- Prefer not to answer

47. What sex were you assigned at birth?

- Male
- Female
- Trans Man
- Trans Woman
- Othere
- Prefer not to answer

48. What is your sexual orientation?

- Asexual
- Bisexual
- Gay
- Lesbian
- Straight (Heterosexual)
- Pan-sexual
- Queer
- Questioning or unsure
- Prefer not to answer

49. How old are you: _____ years old

50. How much do you weigh: _____ lbs

51. How tall are you? _____ feet _____ inches

52. What is your ethnicity/ancestry?

- Hispanic or latino
- White – European
- Asian
- Black
- Native American
- Pacific Islander
- Don't know
- Prefer not to answer

53. What is the level of your usual physical activity?

- I read, watch TV, and perform chores that are not physically taxing
- I walk, bike, or are otherwise physically active for many days a week. Including among other activities: walking, hunting, and light gardening work
- I do endurance sports for several hours a week. Including jogging, skiing, weight lifting, calisthenics, swimming, ball games or physically taxing gardening work.
- I train for competitive sports daily

54. Do you smoke?

- I have never smoked regularly.
- I used to smoke, but I quit.
- I smoke only rarely.
- I smoke every day. How many cigarettes on average per day: _____

55. Do you vape?

- I have never vaped regularly.
- I used to vape, but I quit.
- I vape only rarely.
- I vape every day.

56. How often do you consume alcoholic beverages

- never
- once a month or less often
- 2-4 times a month
- 2-3 times a week
- 4 times a week or more often

57. When thinking about your usual alcohol consumption over the past year, how much do you usually drink in one week: _____

58. What is your education level?

- Primary/elementary school
- Vocational school

- High school
- College / Bachelors degree
- Masters degree or higher

59. What is your job title: _____

60. Over the last year, were you a health care worker?

- Yes
- No

61. Over the last year, have you worked as a teacher or worked in childcare services?

- Yes
- No

62. Over the last year, have you worked in the food service industry?

- Yes
- No

63. Do you usually commute by mass transit (subway, train, bus)?

- Yes
- No

64. Do you usually commute by driving, using taxis, or car share services?

- Yes
- No

65. Over the past week, how often have you been feeling nervous, anxious, or on edge

- Not at all
- Several days
- More than half the days
- Nearly every day

66. Over the past week, how often have you not been able to stop worrying

- Not at all
- Several days
- More than half the days
- Nearly every day

67. Many patients may also feel loneliness during this time. How often have you felt lonely during the past week?

- Not at all
- Several days
- More than half the days
- Nearly every day

For participants under 18 years old, parents should answer the following questions on behalf of the child.

68. Was your child born premature (before 37 weeks)?

- Yes
- No

69. Was your child breastfed?

- Yes
- No

70. If yes, for how long?

- 1 month -12 months
- >12 months

For women, the following questions are about pregnancies:

71. Are you pregnant or have you delivered in the last month?

- I am currently pregnant
- I delivered within the last month
- No, I am not currently pregnant and have not recently delivered a baby

72. My current gestation in pregnancy is:

- 6 to 14 weeks
- 14 to 24 weeks
- 24 to 32 weeks
- 32 to 36 weeks
- Over 36 weeks

73. Have you had any complications with the pregnancy since having the COVID-19 infection?

- Yes
- No

74. If yes, what of the following complications did you have?

- Miscarriage, if so how many times _____
- Premature labor
- Pre-eclampsia
- Other

75. Are you currently breastfeeding?

- Yes
- No

76. How many children have you given birth to? _____

If there are members of your family who you believe have been infected with COVID-19 who you would like to be part of this study, please provide their name(s) and contact information below.

Name:

Email address:

Phone number:

Name:

Email address:

Phone number