Alcohol and Tobacco

Alcohol and tobacco form version:

_____

Placeholder to attach form-level queries

_____

(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of Alcohol and Tobacco form collection:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language

_____

Please answer the following questions for the 12 months before [stem_your]:

In the 12 months before [stem_your], did you use any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes or smokeless tobacco)?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you use e-cigarettes or vapes for tobacco?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you have 5 or more drinks containing alcohol in one day?One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you have 4 or more drinks containing alcohol in one day?One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you use any form of marijuana?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you use pens, THC cartridges, or vapes for marijuana?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you use any drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

In the 12 months before [stem_your], did you use any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone), medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin), or medications for ADHD (for example, Adderall or Ritalin)

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

_section collection language

Please answer the following questions for the time since [stem_your]:

Since [stem_your], have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes or smokeless tobacco)?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you used e-cigarettes or vapes for tobacco?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you had 5 or more drinks containing alcohol in one day?One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you had 4 or more drinks containing alcohol in one day?One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you used any form of marijuana?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you used pens, THC cartridges, or vapes for marijuana?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you used any drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

Since [stem_your], have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone), medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin), or medications for ADHD (for example, Adderall or Ritalin)

◯ Daily or Almost Daily
◯ Weekly
◯ Monthly
◯ Less than Monthly
◯ Never
◯ Prefer not to answer

COVID Treatment

Covid treatment form version: _____

Placeholder to attach form-level queries _____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Error: this participant has not had COVID. This instrument should not be collected. Please choose to cancel the instrument; do not save it.

Date of COVID Treatment form collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language _____

Some people may have had COVID more than once. How many times do you think you have had COVID, including your first infection on [enrollment_arm_1][index_dt]?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5 or more

This next series of questions is about your first COVID infection.

What was the date of your first COVID infection? If you do not remember the exact date, please give your best guess. _____

What kind of medical care did you get the first time you had COVID around [rx_infdt]? Check all that apply.

☐ I had no symptoms
☐ I managed my symptoms at home by myself
☐ I managed my symptoms at home and saw a doctor about it (in person or by telehealth)
☐ I visited the emergency department
☐ I was admitted to the hospital
☐ I don't remember
☐ Prefer not to answer

Were you treated with any of the following during your first COVID illness around [rx_infdt]?	Yes	No	I don't know	I prefer not to answer
Nasal cannula (tube in nose) for oxygen	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with steroids (e.g. dexamethasone, solumedrol, prednisone)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with hydroxychloroquine	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with monoclonal antibody	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with remdesivir	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with other antiviral drug (e.g. lopinavir, ritonavir, nirmatrelvir/ritonavir (Paxlovid), molnupiravir, etc.)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with convalescent plasma	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?				
Treatment with anticoagulation (e.g. aspirin, heparin, warfarin (Coumadin), enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc.)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment with antibiotics (e.g. azithromycin (Z-pack, Zithromax), levofloxacin (Levoquin), amoxicillin/clavulonic acid (Augmentin), etc.)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment with ivermectin	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment with fluvoxamine (Luvox)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment in the intensive care unit	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Mechanical ventilation (intubated; placed on a machine to help you breathe through a tube down your throat)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

ECMO (extracorporeal membrane oxygenation, bypass machine for oxygen)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment with IL-6 antagonist (e.g. tocilizumab (Actemra), sarilumab (Kevzara), siltuximab (Sylvant), etc.)	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment with IL-1 antagonist (anakinra (Kineret), canakinumab (Ilaris))	○	○	○	○

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Treatment with kinase inhibitor (e.g. acalabrutinib (Calquence), ibrutinib (Imbruvica), zanubrutinib (Brukinsa), baricitinib (Olumiant), ruxolitinib (Jakafi), tofacitinib (Xeljanz), etc.)	◯	◯	◯	◯

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

COVID experimental treatment trial	◯	◯	◯	◯

Were you treated with any of the following during your first COVID illness around [rx_infdt]?

Other treatment	◯	◯	◯	◯

Please specify what other treatment you received: _____

Name of the COVID experimental treatment trial (if known): _____

Date enrolled in [rx_coenrollname] trial (best estimate): _____

Name of the treatment(s) being tested (if known): _____

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo: _____

This next series of questions is about your second COVID infection.

What was the date of your second COVID infection? If you do not remember the exact date, please give your best guess. _____

What kind of medical care did you get the second time you had COVID around [rx_infdt_2]? Check all that apply.

☐ I had no symptoms
☐ I managed my symptoms at home by myself
☐ I managed my symptoms at home and saw a doctor about it (in person or by telehealth)
☐ I visited the emergency department
☐ I was admitted to the hospital
☐ I don't remember
☐ Prefer not to answer

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?	Yes	No	I don't know	I prefer not to answer
Nasal cannula (tube in nose) for oxygen	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with steroids (e.g. dexamethasone, solumedrol, prednisone)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with hydroxychloroquine	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with monoclonal antibody	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with remdesivir	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with other antiviral drug (e.g. lopinavir, ritonavir, nirmatrelvir/ritonavir (Paxlovid), molnupiravir, etc.)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with convalescent plasma	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with anticoagulation (e.g. aspirin, heparin, warfarin (Coumadin), enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc.)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with antibiotics (e.g. azithromycin (Z-pack, Zithromax), levofloxacin (Levoquin), amoxicillin/clavulonic acid (Augmentin), etc.)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with ivermectin	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with fluvoxamine (Luvox)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment in the intensive care unit	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Mechanical ventilation (intubated; placed on a machine to help you breathe through a tube down your throat)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
ECMO (extracorporeal membrane oxygenation, bypass machine for oxygen)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with IL-6 antagonist (e.g. tocilizumab (Actemra), sarilumab (Kevzara), siltuximab (Sylvant), etc.)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with IL-1 antagonist (anakinra (Kineret), canakinumab (Ilaris))	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Treatment with kinase inhibitor (e.g. acalabrutinib (Calquence), ibrutinib (Imbruvica), zanubrutinib (Brukinsa), baricitinib (Olumiant), ruxolitinib (Jakafi), tofacitinib (Xeljanz), etc.)	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
COVID experimental treatment trial	○	○	○	○

Were you treated with any of the following during your second COVID illness around [rx_infdt_2]?				
Other treatment	○	○	○	○

Please specify what other treatment you received: _____

Name of the COVID experimental treatment trial (if known): _____

Date enrolled in [rx_coenrollname_2] trial (best estimate): _____

Name of the treatment(s) being tested (if known): _____

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo: _____

This next series of questions is about your third COVID infection.

What was the date of your third COVID infection? If you do not remember the exact date, please give your best guess. _____

What kind of medical care did you get the third time you had COVID around [rx_infdt_3]? Check all that apply.

☐ I had no symptoms
☐ I managed my symptoms at home by myself
☐ I managed my symptoms at home and saw a doctor about it (in person or by telehealth)
☐ I visited the emergency department
☐ I was admitted to the hospital
☐ I don't remember
☐ Prefer not to answer

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?

	Yes	No	I don't know	I prefer not to answer
Nasal cannula (tube in nose) for oxygen	◯	◯	◯	◯

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?

Treatment with steroids (e.g. dexamethasone, solumedrol, prednisone)	◯	◯	◯	◯

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?

Treatment with hydroxychloroquine	◯	◯	◯	◯

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with monoclonal antibody	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with remdesivir	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with other antiviral drug (e.g. lopinavir, ritonavir, nirmatrelvir/ritonavir (Paxlovid), molnupiravir, etc.)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with convalescent plasma	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with anticoagulation (e.g. aspirin, heparin, warfarin (Coumadin), enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc.)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with antibiotics (e.g. azithromycin (Z-pack, Zithromax), levofloxacin (Levoquin), amoxicillin/clavulonic acid (Augmentin), etc.)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with ivermectin	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with fluvoxamine (Luvox)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment in the intensive care unit	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Mechanical ventilation (intubated; placed on a machine to help you breathe through a tube down your throat)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
ECMO (extracorporeal membrane oxygenation, bypass machine for oxygen)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with IL-6 antagonist (e.g. tocilizumab (Actemra), sarilumab (Kevzara), siltuximab (Sylvant), etc.)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with IL-1 antagonist (anakinra (Kineret), canakinumab (Ilaris))	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?				
Treatment with kinase inhibitor (e.g. acalabrutinib (Calquence), ibrutinib (Imbruvica), zanubrutinib (Brukinsa), baricitinib (Olumiant), ruxolitinib (Jakafi), tofacitinib (Xeljanz), etc.)	○	○	○	○

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?

COVID experimental treatment trial	◯	◯	◯	◯

Were you treated with any of the following during your third COVID illness around [rx_infdt_3]?

Other treatment	◯	◯	◯	◯

Please specify what other treatment you received: _____

Name of the COVID experimental treatment trial (if known): _____

Date enrolled in [rx_coenrollname_4] trial (best estimate): _____

Name of the treatment(s) being tested (if known): _____

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo: _____

This next series of questions is about your third COVID infection.

What was the date of your fourth COVID infection? If you do not remember the exact date, please give your best guess. _____

What kind of medical care did you get the fourth time you had COVID around [rx_infdt_4]? Check all that apply.

☐ I had no symptoms
☐ I managed my symptoms at home by myself
☐ I managed my symptoms at home and saw a doctor about it (in person or by telehealth)
☐ I visited the emergency department
☐ I was admitted to the hospital
☐ I don't remember
☐ Prefer not to answer

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?	Yes	No	I don't know	I prefer not to answer
Nasal cannula (tube in nose) for oxygen	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with steroids (e.g. dexamethasone, solumedrol, prednisone)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with hydroxychloroquine	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with monoclonal antibody	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with remdesivir	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with other antiviral drug (e.g. lopinavir, ritonavir, nirmatrelvir/ritonavir (Paxlovid), molnupiravir, etc.)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with convalescent plasma	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?

Treatment with anticoagulation (e.g. aspirin, heparin, warfarin (Coumadin), enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc.)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with antibiotics (e.g. azithromycin (Z-pack, Zithromax), levofloxacin (Levoquin), amoxicillin/clavulonic acid (Augmentin), etc.)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with ivermectin	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with fluvoxamine (Luvox)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment in the intensive care unit	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Mechanical ventilation (intubated; placed on a machine to help you breathe through a tube down your throat)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
ECMO (extracorporeal membrane oxygenation, bypass machine for oxygen)	○	○	○	○

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with IL-6 antagonist (e.g. tocilizumab (Actemra), sarilumab (Kevzara), siltuximab (Sylvant), etc.)	◯	◯	◯	◯

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with IL-1 antagonist (anakinra (Kineret), canakinumab (Ilaris))	◯	◯	◯	◯

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Treatment with kinase inhibitor (e.g. acalabrutinib (Calquence), ibrutinib (Imbruvica), zanubrutinib (Brukinsa), baricitinib (Olumiant), ruxolitinib (Jakafi), tofacitinib (Xeljanz), etc.)	◯	◯	◯	◯

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
COVID experimental treatment trial	◯	◯	◯	◯

Were you treated with any of the following during your fourth COVID illness around [rx_infdt_4]?				
Other treatment	◯	◯	◯	◯

Please specify what other treatment you received: _____

Name of the COVID experimental treatment trial (if known): _____

Date enrolled in [rx_coenrollname_4] trial (best estimate): _____

Name of the treatment(s) being tested (if known): _____

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo: _____

This next series of questions is about your fifth COVID infection.

What was the date of your fifth COVID infection? If you do not remember the exact date, please give your best guess. _____

What kind of medical care did you get the fifth time you had COVID around [rx_infdt_5]? Check all that apply.

☐ I had no symptoms
☐ I managed my symptoms at home by myself
☐ I managed my symptoms at home and saw a doctor about it (in person or by telehealth)
☐ I visited the emergency department
☐ I was admitted to the hospital
☐ I don't remember
☐ Prefer not to answer

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?	Yes	No	I don't know	I prefer not to answer
Nasal cannula (tube in nose) for oxygen	◯	◯	◯	◯
Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with steroids (e.g. dexamethasone, solumedrol, prednisone)	◯	◯	◯	◯
Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with hydroxychloroquine	◯	◯	◯	◯
Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with monoclonal antibody	◯	◯	◯	◯
Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with remdesivir	◯	◯	◯	◯

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with other antiviral drug (e.g. lopinavir, ritonavir, nirmatrelvir/ritonavir (Paxlovid), molnupiravir, etc.)	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with convalescent plasma	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with anticoagulation (e.g. aspirin, heparin, warfarin (Coumadin), enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc.)	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with antibiotics (e.g. azithromycin (Z-pack, Zithromax), levofloxacin (Levoquin), amoxicillin/clavulonic acid (Augmentin), etc.)	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with ivermectin	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with fluvoxamine (Luvox)	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment in the intensive care unit	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Mechanical ventilation (intubated; placed on a machine to help you breathe through a tube down your throat)	○	○	○	○

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
ECMO (extracorporeal membrane oxygenation, bypass machine for oxygen)	◯	◯	◯	◯

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with IL-6 antagonist (e.g. tocilizumab (Actemra), sarilumab (Kevzara), siltuximab (Sylvant), etc.)	◯	◯	◯	◯

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with IL-1 antagonist (anakinra (Kineret), canakinumab (Ilaris))	◯	◯	◯	◯

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Treatment with kinase inhibitor (e.g. acalabrutinib (Calquence), ibrutinib (Imbruvica), zanubrutinib (Brukinsa), baricitinib (Olumiant), ruxolitinib (Jakafi), tofacitinib (Xeljanz), etc.)	◯	◯	◯	◯

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
COVID experimental treatment trial	◯	◯	◯	◯

Were you treated with any of the following during your fifth COVID illness around [rx_infdt_5]?				
Other treatment	◯	◯	◯	◯

Please specify what other treatment you received: _____

Name of the COVID experimental treatment trial (if known): _____

Date enrolled in [rx_coenrollname_5] trial (best estimate): _____

Name of the treatment(s) being tested (if known): _____

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo: _____

Demographics

Demographics form version:

_____

Placeholder to attach form-level queries

_____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of Demographic Data Collection

_____
(MM/DD/YYYY)

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language

_____

Which of these categories describe you (select all that apply)?
(Select all that apply)

☐ American Indian or Alaska Native(For example: Aztec, Blackfeet Tribe, Mayan, Navajo Nation, Native Village of Barrow (Utqiagvik) Inupiat Traditional Government, Nome Eskimo Community, etc.)
☐ Asian(For example: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, etc.)
☐ Black or African American(For example: African American, Ethiopian, Haitian, Jamaican, Nigerian, Somali, etc.)
☐ Hispanic, Latino, or Spanish(For example: Colombian, Cuban, Dominican, Mexican or Mexican American, Puerto Rican, Salvadoran, etc.)
☐ Middle Eastern or North African(For example: Algerian, Egyptian, Iranian, Lebanese, Moroccan, Syrian, etc.)
☐ Native Hawaiian or other Pacific Islander(For example: Chamorro, Fijian, Marshallese, Native Hawaiian, Tongan, etc.)
☐ White(For example: English, European, French, German, Irish, Italian, Polish, etc.)
☐ None of these fully describe me
☐ Prefer not to answer

Please choose what category of American Indian or Alaskan Native best describes you:

◯ American Indian
◯ Alaska Native
◯ Central or South American Indian
◯ None of these fully describe me
◯ Prefer not to answer

Please choose what categories of Asian descent best describe you (select all that apply):
(Select all that apply)

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Pakistani
- ☐ Vietnamese
- ☐ Other Asian descent
- ☐ Prefer not to answer

Please choose what categories of Black or African descent best describe you (select all that apply):
(Select all that apply)

- ☐ African American
- ☐ Barbadian
- ☐ Caribbean
- ☐ Ethiopian
- ☐ Ghanaian
- ☐ Haitian
- ☐ Jamaican
- ☐ Liberian
- ☐ Nigerian
- ☐ Somali
- ☐ South African
- ☐ Other Black or African descent
- ☐ Prefer not to answer

Please choose which categories of Hispanic descent best describe you (select all that apply):
(Select all that apply)

- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ Ecuadorian
- ☐ Honduran
- ☐ Mexican or Mexican American
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Spanish
- ☐ Other Hispanic descent
- ☐ Prefer not to answer

Please choose which categories of Middle Eastern or North African descent best describe you (select all that apply):
(Select all that apply)

- ☐ Afghan
- ☐ Algerian
- ☐ Egyptian
- ☐ Iranian
- ☐ Iraqi
- ☐ Israeli
- ☐ Lebanese
- ☐ Moroccan
- ☐ Syrian
- ☐ Tunisian
- ☐ Other Middle Eastern or North African descent
- ☐ Prefer not to answer

Please choose which categories of Native Hawaiian or Pacific Islander descent best describe you (select all that apply):
(Select all that apply)

- ☐ Chamorro
- ☐ Chuukese
- ☐ Fijian
- ☐ Kosraen
- ☐ Maori
- ☐ Marshallese
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Palauan
- ☐ Pohnpeian
- ☐ Samoan
- ☐ Tahitian
- ☐ Tongan
- ☐ Yapese
- ☐ Other Pacific Islander descent
- ☐ Prefer not to answer

Please choose which categories of White or European descent best describe you (select all that apply):
(Select all that apply)

- ☐ Dutch
- ☐ English
- ☐ French
- ☐ German
- ☐ Irish
- ☐ Italian
- ☐ Norwegian
- ☐ Polish
- ☐ Russian
- ☐ Scottish
- ☐ Spanish
- ☐ Other White or European descent
- ☐ Prefer not to answer

Please specify other categories: _____

What was your sex assigned at birth?

◯ Female
◯ Male
◯ Intersex

What terms best express how you describe your gender identity (select all that apply)?
(Select all that apply)

☐ Woman
☐ Man
☐ Non-binary
☐ Transgender
☐ None of these describe me and I'd like to consider additional options
☐ Prefer not to answer

Are any of these a closer description to your gender identity (select all that apply)?
(Select all that apply)

☐ Transman/Transgender Man/FTM
☐ Transwoman/Transgender Woman/MTF
☐ Genderqueer
☐ Genderfluid
☐ Gender variant
☐ Questioning or unsure of your gender identity
☐ None of these describe me
☐ Prefer not to answer

Which of the following best represents how you think of yourself at this time?

◯ Gay
◯ Lesbian
◯ Straight; that is, not gay or lesbian, etc.
◯ Bisexual
◯ None of these describe me and I'd like to see additional options
◯ Prefer not to answer

Are any of these a closer description of how you think of yourself?

◯ Queer
◯ Polysexual, omnisexual, sapiosexual or pansexual
◯ Asexual
◯ Two-spirit
◯ Have not figured out or are in the process of figuring our your sexuality
◯ Mostly straight, but sometimes attracted to people of your own sex
◯ Do not think of yourself as having sexuality
◯ Do not use labels to identify yourself
◯ Don't know the answer
◯ No, I mean something else
◯ Prefer not to answer

Please specify: _____

What is the highest level of education you have achieved outside or in the United States?Grades are roughly equivalent to years of school.

◯ Have never gone to school
◯ 5th grade or less
◯ 6th to 8th grade
◯ 9th to 12th grade, no diploma
◯ High school graduate or GED completed
◯ Some college level/ Technical / Vocational degree
◯ Bachelor's degree
◯ Other advanced degree (Master's, Doctoral degree)
◯ Prefer not to answer

Disability

Disability form version:

Placeholder to attach form-level queries

(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of Disability form collection:

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language

	Yes	No	Prefer not to answer
Before [stem_your]:			
Were you deaf, or did you have serious difficulty hearing?	○	○	○
Before [stem_your]:			
Were you blind, or did you have serious difficulty seeing, even when wearing glasses?	○	○	○
Before [stem_your]:			
Because of a physical, mental, or emotional condition, did you have serious difficulty concentrating, remembering, or making decisions?	○	○	○
Before [stem_your]:			
Did you have serious difficulty walking or climbing stairs?	○	○	○
Before [stem_your]:			
Did you have difficulty dressing or bathing?	○	○	○

Before [stem_your]:			
Because of a physical, mental, or emotional condition, did you have difficulty doing errands alone such as visiting a doctor's office or shopping?	○	○	○

Long COVID Treatment

Long COVID treatment trial tracking form version: _____

Placeholder to attach form-level queries

_____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Error: this participant has not had COVID. This instrument should not be collected. Please choose to cancel the instrument; do not save it.

_form collection language

_____

Date of Long COVID Treatment Trial form collection:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

Are you receiving treatment for any long-term symptoms related to your COVID infection? (Select all that apply)

☐ Prescription medication / infusions (please also list these on your medication survey)
☐ Non-prescription medication / supplement / vitamin (please also list these on your medication survey)
☐ Special diet
☐ Physical rehabilitation
☐ Cognitive (brain) rehabilitation
☐ Talk (mental health) therapy
☐ Hyperbaric oxygen
☐ Other
☐ I am not receiving any of these treatments
☐ I do not have any long-term symptoms related to my COVID infection

Please provide details of these treatments:

Have you enrolled in a long COVID treatment trial [stem_sincein]?

◯ Yes
◯ No

Is this long COVID treatment trial a RECOVER clinical trial?

◯ Yes
◯ No

Which RECOVER clinical trial are you enrolled in?

☐ RECOVER Autonomic
☐ RECOVER Energize
☐ RECOVER Neuro
☐ RECOVER Sleep
☐ RECOVER Vital

Participant ID for RECOVER Autonomic (if known): _____

Participant ID for RECOVER Energize (if known): _____

Participant ID for RECOVER Neuro (if known): _____

Participant ID for RECOVER Sleep (if known): _____

Participant ID for RECOVER Vital (if known): _____

Name of the Long COVID experimental treatment trial (if known): _____

Date enrolled in [lct_coenrollname] trial (best estimate): _____

Name of the treatment(s) being tested (if known): _____

Type of the treatment(s) being tested (if known):

◯ New drug
◯ Existing drug
◯ Over-the-counter or non-drug treatment

How long is (or was) this this trial?

◯ Less than 1 year
◯ 1 year or less than 2 years
◯ 2 years or less than 3 years
◯ 3 years or less than 4 years
◯ 4 years or more

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo: _____

Medical History

Comorbidities form version: _____

Placeholder to attach form-level queries _____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of Comorbidities form collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language _____

Have you been diagnosed with any of the following conditions?

Have you been diagnosed with any of the following conditions in [stem_the]?

Immunocompromised condition (such as a transplant, HIV, or an immune deficiency):

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Prefer not to answer

Immunocompromised condition (such as a transplant, HIV, or an immune deficiency):

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Immunocompromised condition (such as a transplant, HIV, or an immune deficiency):

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Immunocompromised condition (such as a transplant, HIV, or an immune deficiency):

◯ Yes
◯ No
◯ I prefer not to answer

Have you had a transplant?

◯ Yes
◯ No
◯ Prefer not to answer

What type of transplant?

- ☐ Heart
- ☐ Lung
- ☐ Kidney
- ☐ Liver
- ☐ Bone marrow
- ☐ Prefer not to answer

Rheumatologic, autoimmune or connective tissue disease

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ I prefer not to answer

Rheumatologic, autoimmune or connective tissue disease

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ Yes, diagnosed for the first time after [stem_my]
- ◯ I prefer not to answer

Rheumatologic, autoimmune or connective tissue disease

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time on or after [stem_my]
- ◯ I prefer not to answer

Rheumatologic, autoimmune or connective tissue disease

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

Which rheumatologic, autoimmune or connective tissue disease(s) do you have?

- ☐ Anti-phospholipid syndrome
- ☐ Lupus (systemic lupus erythematosus)
- ☐ Sjogren's syndrome
- ☐ Graves' hyperthyroidism
- ☐ Hashimoto's thyroiditis
- ☐ Celiac disease
- ☐ Guillain-Barre syndrome
- ☐ Sarcoidosis
- ☐ Autoimmune encephalitis
- ☐ Multiple sclerosis
- ☐ Myasthenia gravis
- ☐ Mixed connective tissue disorder
- ☐ Systemic sclerosis, scleroderma, CREST syndrome
- ☐ Inflammatory bowel disease (Crohn's or ulcerative colitis)
- ☐ Rheumatoid arthritis
- ☐ Psoriasis or psoriatic arthritis
- ☐ Ankylosing spondylitis
- ☐ Giant cell arteritis
- ☐ ANCA-associated vasculitis
- ☐ Polymyalgia rheumatica
- ☐ Temporal arteritis
- ☐ Other vasculitis
- ☐ Other
- ☐ Don't know exact type
- ☐ I prefer not to answer

Current cancer or ongoing cancer treatment:

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ I prefer not to answer

Current cancer or ongoing cancer treatment:

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ Yes, diagnosed for the first time after [stem_my]
- ◯ I prefer not to answer

Current cancer or ongoing cancer treatment:

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time on or after [stem_my]
- ◯ I prefer not to answer

Current cancer or ongoing cancer treatment:

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

What type(s) of cancer do you currently have (or are you undergoing treatment for)?

- ☐ Bladder cancer
- ☐ Blood or soft tissue cancer
- ☐ Bone cancer
- ☐ Brain cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer/Rectal cancer
- ☐ Endocrine cancer
- ☐ Endometrial cancer
- ☐ Esophageal cancer
- ☐ Eye cancer
- ☐ Head and Neck cancer
- ☐ Kidney cancer
- ☐ Lung cancer
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Stomach cancer
- ☐ Thyroid cancer
- ☐ Other cancer
- ☐ I prefer not to answer

Chronic liver disease

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ I prefer not to answer

Chronic liver disease

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ Yes, diagnosed for the first time after [stem_my]
- ◯ I prefer not to answer

Chronic liver disease

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time on or after [stem_my]
- ◯ I prefer not to answer

Chronic liver disease

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

_section collection language

_____

Obesity

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Obesity

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Obesity

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Obesity

◯ Yes
◯ No
◯ I prefer not to answer

Diabetes

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Diabetes

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Diabetes

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Diabetes

◯ Yes
◯ No
◯ I prefer not to answer

Which type of diabetes do you have?

◯ Type 1
◯ Type 2
◯ Mixed
◯ Don't know
◯ Prefer not to answer

Kidney disease

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Kidney disease

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Kidney disease

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Kidney disease

◯ Yes
◯ No
◯ I prefer not to answer

Do you undergo dialysis for your kidney disease?

◯ Yes
◯ No
◯ Prefer not to answer

When did you start dialysis?
Please specify the first day of the correct month and year.

_____

Error: The date you started dialysis must be in the past.

_section collection language

_____

High blood pressure, with or without treatment (hypertension, HTN)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

High blood pressure, with or without treatment (hypertension, HTN)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

High blood pressure, with or without treatment (hypertension, HTN)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

High blood pressure, with or without treatment (hypertension, HTN)

◯ Yes
◯ No
◯ I prefer not to answer

Cardiovascular disease (e.g., heart failure, heart attack, high blood pressure)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Cardiovascular disease (e.g., heart failure, heart attack, high blood pressure)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Cardiovascular disease (e.g., heart failure, heart attack, high blood pressure)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Cardiovascular disease (e.g., heart failure, heart attack, high blood pressure)

◯ Yes
◯ No
◯ I prefer not to answer

Which specific type(s) of cardiovascular disease do you have?

- ☐ Congestive heart failure (CHF, heart failure)
- ☐ Coronary artery disease (angina, heart attack, stent, bypass surgery)
- ☐ Myocarditis
- ☐ High blood pressure with or without treatment (hypertension)
- ☐ Atrial fibrillation
- ☐ Heart valve disease
- ☐ Congenital heart disease
- ☐ Other
- ☐ Don't know exact type
- ☐ I prefer not to answer

Stroke, TIA (transient ischemic attack or mini-stroke), intracerebral hemorrhage or subarachnoid hemorrhage (bleeding in the brain), or cerebral venous thrombosis (type of blood clot in the brain)

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ I prefer not to answer

Stroke, TIA (transient ischemic attack or mini-stroke), intracerebral hemorrhage or subarachnoid hemorrhage (bleeding in the brain), or cerebral venous thrombosis (type of blood clot in the brain)

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ Yes, diagnosed for the first time after [stem_my]
- ◯ I prefer not to answer

Stroke, TIA (transient ischemic attack or mini-stroke), intracerebral hemorrhage or subarachnoid hemorrhage (bleeding in the brain), or cerebral venous thrombosis (type of blood clot in the brain)

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time on or after [stem_my]
- ◯ I prefer not to answer

Stroke, TIA (transient ischemic attack or mini-stroke), intracerebral hemorrhage or subarachnoid hemorrhage (bleeding in the brain), or cerebral venous thrombosis (type of blood clot in the brain)

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

Which specific type(s) of stroke, hemorrhage, or thrombosis?

- ☐ Ischemic stroke or transient ischemic attack (mini stroke)
- ☐ Intraparenchymal hemorrhage or intraventricular hemorrhage (bleeding in brain)
- ☐ Subarachnoid hemorrhage (bleeding between the brain and the skull)
- ☐ Cerebral venous thrombosis or cerebral sinus thrombosis
- ☐ Other
- ☐ Don't know exact type
- ☐ I prefer not to answer

_section collection language

Asthma

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Asthma

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Asthma

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Asthma

◯ Yes
◯ No
◯ I prefer not to answer

Chronic obstructive pulmonary disease (COPD) including emphysema, chronic bronchitis, obstructive pulmonary disease

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Chronic obstructive pulmonary disease (COPD) including emphysema, chronic bronchitis, obstructive pulmonary disease

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Chronic obstructive pulmonary disease (COPD) including emphysema, chronic bronchitis, obstructive pulmonary disease

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Chronic obstructive pulmonary disease (COPD) including emphysema, chronic bronchitis, obstructive pulmonary disease

◯ Yes
◯ No
◯ I prefer not to answer

Other chronic lung disease

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Other chronic lung disease

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Other chronic lung disease

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Other chronic lung disease

◯ Yes
◯ No
◯ I prefer not to answer

Use of oxygen at home

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Use of oxygen at home

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Use of oxygen at home

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Use of oxygen at home

◯ Yes
◯ No
◯ I prefer not to answer

Sickle cell anemia

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Sickle cell anemia

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Sickle cell anemia

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Sickle cell anemia

◯ Yes
◯ No
◯ I prefer not to answer

_section collection language

_____

Dementia, memory impairment, cognitive disorder, or developmental delay

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Dementia, memory impairment, cognitive disorder, or developmental delay

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Dementia, memory impairment, cognitive disorder, or developmental delay

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Dementia, memory impairment, cognitive disorder, or developmental delay

◯ Yes
◯ No
◯ I prefer not to answer

Depression or anxiety disorder

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Depression or anxiety disorder

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Depression or anxiety disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Depression or anxiety disorder

◯ Yes
◯ No
◯ I prefer not to answer

Bipolar disorder or psychosis (hearing or seeing things others can't; odd or unusual beliefs; paranoia)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Bipolar disorder or psychosis (hearing or seeing things others can't; odd or unusual beliefs; paranoia)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Bipolar disorder or psychosis (hearing or seeing things others can't; odd or unusual beliefs; paranoia)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Bipolar disorder or psychosis (hearing or seeing things others can't; odd or unusual beliefs; paranoia)

◯ Yes
◯ No
◯ I prefer not to answer

Other mental health disorder

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Other mental health disorder

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Other mental health disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Other mental health disorder

◯ Yes
◯ No
◯ I prefer not to answer

_section collection language

_____

Chronic pain syndrome or fibromyalgia

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Chronic pain syndrome or fibromyalgia

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Chronic pain syndrome or fibromyalgia

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Chronic pain syndrome or fibromyalgia

◯ Yes
◯ No
◯ I prefer not to answer

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)

◯ Yes
◯ No
◯ I prefer not to answer

POTS (Postural Orthostatic Tachycardia Syndrome) or other form of dysautonomia or autonomic dysfunction

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

POTS (Postural Orthostatic Tachycardia Syndrome) or other form of dysautonomia or autonomic dysfunction

◯ No
◯ Yes, already had this condition during the year before [stem_my]
◯ Yes, diagnosed for the first time at the time of [stem_my]
◯ Yes, diagnosed for the first time after [stem_my]
◯ I prefer not to answer

POTS (Postural Orthostatic Tachycardia Syndrome) or other form of dysautonomia or autonomic dysfunction

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

POTS (Postural Orthostatic Tachycardia Syndrome) or other form of dysautonomia or autonomic dysfunction

◯ Yes
◯ No
◯ I prefer not to answer

Indicate which specific type(s) of dysautonomia you have

- ☐ Postural orthostatic tachycardia syndrome (POTS)
- ☐ Autonomic neuropathy
- ☐ Orthostatic hypotension/intolerance
- ☐ Sympathetic storming, paroxysmal sympathetic hyperactivity
- ☐ Other
- ☐ Don't know exact type
- ☐ I prefer not to answer

Polycystic ovarian syndrome

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ I prefer not to answer

Polycystic ovarian syndrome

- ◯ No
- ◯ Yes, already had this condition during the year before [stem_my]
- ◯ Yes, diagnosed for the first time at the time of [stem_my]
- ◯ Yes, diagnosed for the first time after [stem_my]
- ◯ I prefer not to answer

Polycystic ovarian syndrome

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time on or after [stem_my]
- ◯ I prefer not to answer

Polycystic ovarian syndrome

- ◯ Yes
- ◯ No
- ◯ I prefer not to answer

_section collection language

_____

Central nervous system (brain) infection, inflammatory disease or demyelinating disease

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time at the time of [stem_my]
- ◯ I prefer not to answer

Central nervous system (brain) infection, inflammatory disease or demyelinating disease

- ◯ No
- ◯ Yes, I already had this condition during the year before [stem_my]
- ◯ Yes, I was diagnosed for the first time at the time of [stem_my]
- ◯ Yes, I was diagnosed for the first time after [stem_my]
- ◯ I prefer not to answer

Central nervous system (brain) infection, inflammatory disease or demyelinating disease

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Central nervous system (brain) infection, inflammatory disease or demyelinating disease

◯ Yes
◯ No
◯ I prefer not to answer

Which specific type(s) of central nervous system (brain) infection, inflammatory disease, or demyelinating disease do you have?

☐ Multiple sclerosis
☐ Encephalitis
☐ Meningitis
☐ Transverse myelitis
☐ CNS vasculitis
☐ Other
☐ Prefer not to answer

Seizure disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Seizure disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time at the time of [stem_my]
◯ Yes, I was diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Seizure disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Seizure disorder

◯ Yes
◯ No
◯ I prefer not to answer

Neuromuscular disease (neuropathy, myopathy, myasthenia gravis, etc.)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Neuromuscular disease (neuropathy, myopathy, myasthenia gravis, etc.)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time at the time of [stem_my]
◯ Yes, I was diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Neuromuscular disease (neuropathy, myopathy, myasthenia gravis, etc.)

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Neuromuscular disease (neuropathy, myopathy, myasthenia gravis, etc.)

◯ Yes
◯ No
◯ I prefer not to answer

Which specific type(s) of neuromuscular disease do you have?

☐ Neuropathy
☐ Myopathy
☐ Myasthenia gravis or other neuromuscular junction disorder
☐ Radiculopathy
☐ Guillain-Barre Disease, Acute Inflammatory Demyelinating Polyneuropathy (AIDP), Acute Motor Axonal Neuropathy (AMAN), Miller Fisher, or other variants
☐ Other
☐ Prefer not to answer

Movement disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time at the time of [stem_my]
◯ I prefer not to answer

Movement disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time at the time of [stem_my]
◯ Yes, I was diagnosed for the first time after [stem_my]
◯ I prefer not to answer

Movement disorder

◯ No
◯ Yes, I already had this condition during the year before [stem_my]
◯ Yes, I was diagnosed for the first time on or after [stem_my]
◯ I prefer not to answer

Movement disorder

◯ Yes
◯ No
◯ I prefer not to answer

Which specific type(s) of movement disorder do you have?

☐ Parkinsonism
☐ Essential tremor or other tremor
☐ Tics
☐ Dystonia
☐ Myoclonus
☐ Chorea, Huntington's
☐ Restless legs or periodic limb movements of sleep
☐ Other
☐ Prefer not to answer

We have changed the format of this form. As a result, this first time you fill out the new version, we are asking you to provide us information about conditions at any point, not just since your last visit. We apologize for the extra data collection.

This form will ask about a set of specific conditions. At the end of the form, you will have a chance to write in any other conditions you have that we did not ask about.

Have you been diagnosed with any of the following conditions [cc2_intcalc_your]?

☐ Obesity
☐ Diabetes
☐ Myalgic encephalomyelitis / Chronic fatigue syndrome (ME/CFS)
☐ Chronic pain syndrome or fibromyalgia
☐ Ehlers-Danlos syndrome (EDS, aka elastic skin) including hEDS (hypermobile Ehlers-Danlos syndrome), or hypermobility spectrum disorder
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with obesity?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with diabetes?

_____
(Please provide your best estimate if the exact date is not known)

What type of diabetes do you have?

◯ Type I
◯ Type II
◯ Mixed
◯ Diabetes in pregnancy
◯ I don't know or prefer not to answer

When were you diagnosed with myalgic encephalomyelitis / chronic fatigue syndrome (ME/CFS)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with chronic pain syndrome or fibromyalgia?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with Ehlers-Danlos syndrome (EDS, aka elastic skin, including hEDS (hypermobile Ehlers-Danlos syndrome), or hypermobility spectrum disorder)?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following heart problems [cc2_intcalc_your]?

- ☐ High blood pressure, with or without treatment (hypertension)
- ☐ High cholesterol
- ☐ Congestive heart failure (CHF, heart failure)
- ☐ Coronary artery disease (angina, heart attack, stent, bypass surgery)
- ☐ Myocarditis
- ☐ Pericarditis
- ☐ Atrial fibrillation
- ☐ Other abnormal heart rhythm (too slow (bradycardia); too fast (supraventricular tachycardia, ventricular tachycardia))
- ☐ Heart valve disease
- ☐ Congenital heart disease
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with high blood pressure (hypertension)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with high cholesterol?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with congestive heart failure (CHF, heart failure)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with coronary artery disease (angina, heart attack, stent, bypass surgery)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with myocarditis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with pericarditis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with atrial fibrillation?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with other abnormal heart rhythm (too slow (bradycardia); too fast (supraventricular tachycardia, ventricular tachycardia))?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with heart valve disease?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with congenital heart disease?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following lung problems [cc2_intcalc_your]?

- ☐ Asthma
- ☐ Chronic obstructive pulmonary disease (COPD) including emphysema, chronic bronchitis
- ☐ Other chronic lung disease (such as interstitial lung disease, pulmonary fibrosis, pulmonary inflammation, bleeding, abscess)
- ☐ Use of oxygen at home
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with asthma?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with chronic obstructive pulmonary disease (COPD, including emphysema, or chronic bronchitis)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with other chronic lung disease (such as interstitial lung disease, pulmonary fibrosis, pulmonary inflammation, bleeding, abscess)?

_____
(Please provide your best estimate if the exact date is not known)

When did you start using oxygen at home?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following gastrointestinal, liver, or kidney problems [cc2_intcalc_your]?

- ☐ Gastroesophageal reflux disease (heartburn, GERD)
- ☐ Celiac disease
- ☐ Inflammatory bowel disease (Crohn's or ulcerative colitis)
- ☐ Irritable bowel syndrome
- ☐ Fatty liver
- ☐ Chronic viral hepatitis (hepatitis B or C)
- ☐ Alcoholic liver disease
- ☐ Autoimmune liver disease
- ☐ Cirrhosis of the liver
- ☐ Kidney disease
- ☐ Dialysis
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with gastroesophageal reflux disease (heartburn, GERD)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with celiac disease?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with inflammatory bowel disease (Crohn's or ulcerative colitis)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with irritable bowel syndrome?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with fatty liver?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with chronic viral hepatitis (hepatitis B or C)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with alcoholic liver disease?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with autoimmune liver disease?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with cirrhosis of the liver?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with kidney disease?

_____
(Please provide your best estimate if the exact date is not known)

When did you start dialysis?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following thyroid problems [cc2_intcalc_your]?

☐ Overactive thyroid (Graves' hyperthyroidism)
☐ Underactive thyroid (Hashimoto's thyroiditis, hypothyroidism)
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with overactive thyroid (Graves' hyperthyroidism)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with underactive thyroid (Hashimoto's thyroiditis, hypothyroidism)?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following blood or clotting problems [cc2_intcalc_your]?

☐ Sickle cell anemia
☐ Anemia (low blood count)
☐ Deep venous thrombosis (blood clot in vein)
☐ Pulmonary embolism (blood clot in lung)
☐ Blood clotting problem
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with sickle cell anemia?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with anemia (low blood count)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with deep venous thrombosis (blood clot in vein)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with a pulmonary embolism (blood clot in lung)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with a blood clotting problem?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following joint problems [cc2_intcalc_your]?

☐ Rheumatoid arthritis
☐ Psoriasis or psoriatic arthritis
☐ Ankylosing spondylitis
☐ Reactive arthritis
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with rheumatoid arthritis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with psoriasis or psoriatic arthritis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with ankylosing spondylitis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with reactive arthritis?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following immune system problems [cc2_intcalc_your]?

☐ HIV
☐ Immune deficiency because of medicines
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with HIV?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with an immune deficiency because of medicines?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following autoimmune or rheumatologic problems [cc2_intcalc_your]?

☐ Anti-phospholipid syndrome
☐ Lupus (systemic lupus erythematosus)
☐ Sjogren's syndrome
☐ Sarcoidosis
☐ Mixed connective tissue disorder
☐ Systemic sclerosis, scleroderma, CREST syndrome
☐ Giant cell arteritis
☐ ANCA-associated vasculitis
☐ Polymyalgia rheumatica
☐ Temporal arteritis
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with anti-phospholipid syndrome?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with lupus (systemic lupus erythematosus)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with Sjogren's syndrome?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with sarcoidosis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with a mixed connective tissue disorder?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with systemic sclerosis, scleroderma, or CREST syndrome?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with giant cell arteritis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with ANCA-associated vasculitis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with polymyalgia rheumatica?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with temporal arteritis?

_____
(Please provide your best estimate if the exact date is not known)

Have you had a transplant [cc2_intcalc_your]? If so, which kind?

- ☐ Heart
- ☐ Lung
- ☐ Kidney
- ☐ Liver
- ☐ Bone marrow
- ☐ I have not had a transplant [cc2_intcalc_my]

When did you have a heart transplant?

_____
(Please provide your best estimate if the exact date is not known)

When did you have a lung transplant?

_____
(Please provide your best estimate if the exact date is not known)

When did you have a kidney transplant?

_____
(Please provide your best estimate if the exact date is not known)

When did you have a liver transplant?

_____
(Please provide your best estimate if the exact date is not known)

When did you have a bone marrow transplant?

_____
(Please provide your best estimate if the exact date is not known)

Do you currently have cancer or ongoing cancer treatment? If so, which kind?

- ☐ Bladder cancer
- ☐ Blood or lymph node cancer (leukemia, lymphoma)
- ☐ Bone cancer
- ☐ Brain cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer/Rectal cancer
- ☐ Endocrine cancer
- ☐ Endometrial cancer
- ☐ Esophageal cancer
- ☐ Eye cancer
- ☐ Head and neck cancer
- ☐ Kidney cancer
- ☐ Lung cancer
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Stomach cancer
- ☐ Thyroid cancer
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with bladder cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with blood or or lymph node cancer (leukemia, lymphoma)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with bone cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with brain cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with breast cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with cervical cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with colon cancer/Rectal cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with endocrine cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with endometrial cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with esophageal cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with eye cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with head and neck cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with kidney cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with lung cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with ovarian cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with pancreatic cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with prostate cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with skin cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with stomach cancer?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with thyroid cancer?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following brain or nerve problems [cc2_intcalc_your]?

☐ Seizures
☐ Attention deficit hyperactivity disorder
☐ Dementia or memory impairment
☐ Developmental delay
☐ Autism spectrum disorder
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with seizures?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with attention deficit hyperactivity disorder (ADHD)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with dementia or memory impairment?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with a developmental delay?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with Autism Spectrum Disorder (ASD)?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following dysautonomias [cc2_intcalc_your]?

- ☐ Postural orthostatic tachycardia syndrome (POTS)
- ☐ Autonomic neuropathy
- ☐ Orthostatic hypotension/intolerance
- ☐ Sympathetic storming
- ☐ Paroxysmal sympathetic hyperactivity
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with postural orthostatic tachycardia syndrome (POTS)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with autonomic neuropathy?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with orthostatic hypotension/intolerance?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with sympathetic storming?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with paroxysmal sympathetic hyperactivity?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following headache problems [cc2_intcalc_your]?

☐ Tension headache
☐ Migraine
☐ Cluster headache
☐ Sinus headache
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with tension headaches?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with migraines?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with cluster headaches?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with sinus headaches?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following stroke or brain bleed problems [cc2_intcalc_your]?

☐ Mini stroke (stroke or transient ischemic attack)
☐ Bleeding in brain (intraparenchymal hemorrhage or intraventricular hemorrhage)
☐ Bleeding between the brain and the skull (subarachnoid hemorrhage)
☐ Blood clot in brain (cerebral venous thrombosis or cerebral sinus thrombosis)
☐ Blood clot in eye vessel (retinal vein or artery occlusion)
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with stroke or transient ischemic attack (mini stroke)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with bleeding in brain (intraparenchymal hemorrhage or intraventricular hemorrhage)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with bleeding between the brain and the skull (subarachnoid hemorrhage)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with a blood clot in your brain (cerebral venous thrombosis or cerebral sinus thrombosis)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with a blood clot in your eye vessel (retinal vein or artery occlusion)?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following brain or nerve infections or inflammations [cc2_intcalc_your]?

- ☐ Multiple sclerosis
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Transverse myelitis (inflammation of the spinal cord)
- ☐ CNS vasculitis (blood vessel inflammation in the brain)
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with multiple sclerosis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with encephalitis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with meningitis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with transverse myelitis (inflammation of the spinal cord)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with CNS vasculitis (blood vessel inflammation in the brain)?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following strength or feeling problems [cc2_intcalc_your]?

- ☐ Neuropathy
- ☐ Myopathy
- ☐ Myasthenia gravis or other neuromuscular junction disorder
- ☐ Radiculopathy
- ☐ Guillain-Barre Disease, Acute Inflammatory Demyelinating Polyneuropathy (AIDP), Acute Motor Axonal Neuropathy (AMAN), Miller Fisher, or other variants
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with neuropathy?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with myopathy?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with myasthenia gravis or other neuromuscular junction disorder?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with radiculopathy?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with Guillain-Barre Disease, Acute Inflammatory Demyelinating Polyneuropathy (AIDP), Acute Motor Axonal Neuropathy (AMAN), Miller Fisher, or other variants?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following movement problems [cc2_intcalc_your]?

- ☐ Parkinsonism
- ☐ Essential tremor or other tremor
- ☐ Tics
- ☐ Dystonia
- ☐ Myoclonus
- ☐ Chorea, Huntington's
- ☐ Restless legs or periodic limb movements of sleep
- ☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with Parkinsonism?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with essential tremor or other tremor?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with tics?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with dystonia?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with myoclonus?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with chorea or Huntington's?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with restless legs or periodic limb movements of sleep?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following sleep problems [cc2_intcalc_your]?

☐ Insomnia
☐ Narcolepsy
☐ Circadian rhythm disorder
☐ Obstructive sleep apnea
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with insomnia?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with narcolepsy?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with circadian rhythm disorder?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with obstructive sleep apnea?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following allergy problems [cc2_intcalc_your]?

☐ Chronic or recurrent sinusitis
☐ Mast cell activation syndrome
☐ Seasonal allergies
☐ Food allergies
☐ Chemical allergies
☐ Medication allergies
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with chronic or recurrent sinusitis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with mast cell activation syndrome?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with seasonal allergies?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with food allergies?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with chemical allergies?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with medication allergies?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following infections [cc2_intcalc_your]?

☐ Influenza
☐ Epstein-Barr virus (EBV, mono)
☐ Cytomegalovirus (CMV)
☐ Lyme disease
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with influenza?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with Epstein-Barr virus (EBV, mono)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with cytomegalovirus (CMV)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with Lyme disease?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following gynecologic problems [cc2_intcalc_your]?

☐ Polycystic ovarian syndrome
☐ Endometriosis
☐ Dysmenorrhea (severe menstrual cramps)
☐ Premenstrual dysphoric disorder (mood change)
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with polycystic ovarian syndrome?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with endometriosis?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with dysmenorrhea (severe menstrual cramps)?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with premenstrual dysphoric disorder (mood change)?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any of the following mental health problems [cc2_intcalc_your]?

☐ Depression or anxiety disorder
☐ Post-traumatic stress disorder
☐ Bipolar disorder, schizophrenia or psychosis (hearing or seeing things others can't; odd or unusual beliefs; paranoia)
☐ I have not been diagnosed with any of these conditions [cc2_intcalc_my]

When were you diagnosed with depression or anxiety disorder?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with post-traumatic stress disorder?

_____
(Please provide your best estimate if the exact date is not known)

When were you diagnosed with bipolar disorder, schizophrenia or psychosis?

_____
(Please provide your best estimate if the exact date is not known)

Have you been diagnosed with any other conditions by a health care provider [cc2_intcalc_your]?

◯ Yes
◯ No
◯ I prefer not to answer

What other conditions have you been diagnosed with? Please include the date of diagnosis.

Do you think you have developed any other condition, even if not formally diagnosed, [cc2_intcalc_your]?

◯ Yes
◯ No
◯ I prefer not to answer

What other conditions do you think you have developed?

PASC Symptoms

PASC Symptoms form version:2023-06-01: v62023-07-20: v72023-09-06: v8

Placeholder to attach form-level queries

(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of PASC Symptoms collection:

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is	○	○	○	○	○
In general, would you say your quality of life is	○	○	○	○	○
In general, how would you rate your physical health?	○	○	○	○	○
In general, how would you rate your mental health, including your mood and your ability to think?	○	○	○	○	○
In general, how would you rate your satisfaction with your social activities and relationships?	○	○	○	○	○
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	○	○	○	○	○

To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

◯ Completely
◯ Mostly
◯ Moderately
◯ A little
◯ Not at all

In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

◯ Never
◯ Rarely
◯ Sometimes
◯ Often
◯ Always

In the past 7 days, how would you rate your fatigue on average?

◯ None
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe

In the past 7 days, how would you rate your pain on average?

◯ 0 (No pain)
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 (Worst Imaginable Pain)

Have you had a period in the last 3 months?

◯ Yes
◯ No

Why have you not had a period in the last 3 months?

◯ I am in menopause
◯ I had a hysterectomy
◯ I am pregnant
◯ I am taking a medication or using an IUD that stops my period
◯ My periods come infrequently
◯ Some other reason

_section collection language

_____

Do you think you currently have symptoms or health problems resulting from your COVID infection?

◯ Yes
◯ No
◯ I don't know or prefer not to answer

Please tell us at what time(s) you have had any of the following symptoms. Check all that apply.

	No, I have NOT had this symptom	Yes, I DID have it in the YEAR BEFORE [stem_my]	Yes, I DID have it AROUND the time of [stem_my]	Yes, I have it NOW	I don't know or prefer not to answer
Fatigue (being very tired)	☐	☐	☐	☐	☐
Post-exertional malaise (Symptoms worse after even minor physical or mental effort)	☐	☐	☐	☐	☐
Next day soreness or fatigue after non-strenuous, everyday activities	☐	☐	☐	☐	☐
Weakness in arms or legs	☐	☐	☐	☐	☐
Fever, chills, sweats or flushing	☐	☐	☐	☐	☐
Feeling hot or cold for no reason	☐	☐	☐	☐	☐
Cold limbs (e.g., arms, legs, hands)	☐	☐	☐	☐	☐
Loss of or change in smell or taste	☐	☐	☐	☐	☐
Some smells, foods, medications, or chemicals make you feel sick	☐	☐	☐	☐	☐
Runny nose (allergic rhinitis) or sinus problems	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Pain in any part of your body	☐	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐	☐
Wheezing or whistling in your chest	☐	☐	☐	☐	☐
Persistent (chronic) cough	☐	☐	☐	☐	☐
Palpitations, racing heart, arrhythmia, skipped beats	☐	☐	☐	☐	☐
Swelling of your legs	☐	☐	☐	☐	☐
Gastrointestinal (belly) symptoms (reflux/heartburn, nausea, feeling full or vomiting after eating, diarrhea, constipation)	☐	☐	☐	☐	☐

Bladder problems (incontinence, trouble passing urine or emptying bladder)	☐	☐	☐	☐	☐
Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	☐	☐	☐	☐	☐
Problems with anxiety, depression, stress, or trauma-related symptoms like nightmares or grief	☐	☐	☐	☐	☐
Problems thinking or concentrating ("brain fog")	☐	☐	☐	☐	☐
Stopping breathing during sleep or sleep problems (such as snoring, trouble falling asleep, nighttime awakenings, or trouble staying awake during the day) 3 or more times a week	☐	☐	☐	☐	☐
Feeling faint, dizzy, "goofy"; difficulty thinking soon after standing up from a sitting or lying position	☐	☐	☐	☐	☐
Color changes in your skin, such as red, white or purple	☐	☐	☐	☐	☐
Skin rash	☐	☐	☐	☐	☐
Episodes of itching and/or hives	☐	☐	☐	☐	☐
Episodes of severe allergic reaction (anaphylaxis), with or without any known trigger	☐	☐	☐	☐	☐
Excessively dry eyes	☐	☐	☐	☐	☐
Excessively dry mouth	☐	☐	☐	☐	☐
Excessive thirst	☐	☐	☐	☐	☐
Vision problems (blurry, light sensitivity, difficulty reading or focusing, floaters, flashing lights, "snow")	☐	☐	☐	☐	☐
Problems with hearing (hearing loss, ringing in ears)	☐	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐	☐
Problems with teeth	☐	☐	☐	☐	☐
Changes to menstrual cycle	☐	☐	☐	☐	☐

Changes to menopause symptoms (such as hot flashes)	☐	☐	☐	☐	☐
Changes in fertility or difficulty getting pregnant	☐	☐	☐	☐	☐
Changes in desire for, comfort with or capacity for sex	☐	☐	☐	☐	☐

	No, I have NOT had this symptom	Yes, I DID have it in the YEAR BEFORE [stem_my]	Yes, I DID have it AROUND the time of [stem_my]	Yes, I DID have it BETWEEN 30 DAYS AFTER [stem_my] AND NOW	Yes, I have it NOW	I don't know or prefer not to answer
Fatigue (being very tired)	☐	☐	☐	☐	☐	☐
Post-exertional malaise (Symptoms worse after even minor physical or mental effort)	☐	☐	☐	☐	☐	☐
Next day soreness or fatigue after non-strenuous, everyday activities	☐	☐	☐	☐	☐	☐
Weakness in arms or legs	☐	☐	☐	☐	☐	☐
Fever, chills, sweats or flushing	☐	☐	☐	☐	☐	☐
Feeling hot or cold for no reason	☐	☐	☐	☐	☐	☐
Cold limbs (e.g., arms, legs, hands)	☐	☐	☐	☐	☐	☐
Loss of or change in smell or taste	☐	☐	☐	☐	☐	☐
Some smells, foods, medications, or chemicals make you feel sick	☐	☐	☐	☐	☐	☐
Runny nose (allergic rhinitis) or sinus problems	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐
Pain in any part of your body	☐	☐	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐	☐	☐
Wheezing or whistling in your chest	☐	☐	☐	☐	☐	☐
Persistent (chronic) cough	☐	☐	☐	☐	☐	☐
Palpitations, racing heart, arrhythmia, skipped beats	☐	☐	☐	☐	☐	☐
Swelling of your legs	☐	☐	☐	☐	☐	☐
Gastrointestinal (belly) symptoms (reflux/heartburn, nausea, feeling full or vomiting after eating, diarrhea, constipation)	☐	☐	☐	☐	☐	☐

Bladder problems (incontinence, trouble passing urine or emptying bladder)	☐	☐	☐	☐	☐	☐
Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	☐	☐	☐	☐	☐	☐
Problems with anxiety, depression, stress, or trauma-related symptoms like nightmares or grief	☐	☐	☐	☐	☐	☐
Problems thinking or concentrating ("brain fog")	☐	☐	☐	☐	☐	☐
Stopping breathing during sleep or sleep problems (such as snoring, trouble falling asleep, nighttime awakenings, or trouble staying awake during the day) 3 or more times a week	☐	☐	☐	☐	☐	☐
Feeling faint, dizzy, "goofy"; difficulty thinking soon after standing up from a sitting or lying position	☐	☐	☐	☐	☐	☐
Color changes in your skin, such as red, white or purple	☐	☐	☐	☐	☐	☐
Skin rash	☐	☐	☐	☐	☐	☐
Episodes of itching and/or hives	☐	☐	☐	☐	☐	☐
Episodes of severe allergic reaction (anaphylaxis), with or without any known trigger	☐	☐	☐	☐	☐	☐
Excessively dry eyes	☐	☐	☐	☐	☐	☐
Excessively dry mouth	☐	☐	☐	☐	☐	☐
Excessive thirst	☐	☐	☐	☐	☐	☐
Vision problems (blurry, light sensitivity, difficulty reading or focusing, floaters, flashing lights, "snow")	☐	☐	☐	☐	☐	☐
Problems with hearing (hearing loss, ringing in ears)	☐	☐	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐	☐	☐
Problems with teeth	☐	☐	☐	☐	☐	☐
Changes to menstrual cycle	☐	☐	☐	☐	☐	☐

Changes to menopause symptoms (such as hot flashes)	☐	☐	☐	☐	☐	☐
Changes in fertility or difficulty getting pregnant	☐	☐	☐	☐	☐	☐
Changes in desire for, comfort with or capacity for sex	☐	☐	☐	☐	☐	☐

Did you have any of the following symptoms in [stem_psfu]?

	No	Yes, but not in the last 30 days	Yes, and I STILL HAVE it (in the last 30 days)	I prefer not to answer
Fatigue (being very tired)	◯	◯	◯	◯
Post-exertional malaise (Symptoms worse after even minor physical or mental effort)	◯	◯	◯	◯
Next day soreness or fatigue after non-strenuous, everyday activities	◯	◯	◯	◯
Weakness in arms or legs	◯	◯	◯	◯
Fever, chills, sweats or flushing	◯	◯	◯	◯
Feeling hot or cold for no reason	◯	◯	◯	◯
Cold limbs (e.g., arms, legs, hands)	◯	◯	◯	◯
Loss of or change in smell or taste	◯	◯	◯	◯
Some smells, foods, medications, or chemicals make you feel sick	◯	◯	◯	◯
Runny nose (allergic rhinitis) or sinus problems	◯	◯	◯	◯
Headaches	◯	◯	◯	◯
Pain in any part of your body	◯	◯	◯	◯
Shortness of breath	◯	◯	◯	◯
Wheezing or whistling in your chest	◯	◯	◯	◯
Persistent (chronic) cough	◯	◯	◯	◯
Palpitations, racing heart, arrhythmia, skipped beats	◯	◯	◯	◯
Swelling of your legs	◯	◯	◯	◯
Gastrointestinal (belly) symptoms (reflux/heartburn, nausea, feeling full or vomiting after eating, diarrhea, constipation)	◯	◯	◯	◯

Bladder problems (incontinence, trouble passing urine or emptying bladder)	○	○	○	○
Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	○	○	○	○
Problems with anxiety, depression, stress, or trauma-related symptoms like nightmares or grief	○	○	○	○
Problems thinking or concentrating ("brain fog")	○	○	○	○
Stopping breathing during sleep or sleep problems (such as snoring, trouble falling asleep, nighttime awakenings, or trouble staying awake during the day) 3 or more times a week	○	○	○	○
Feeling faint, dizzy, "goofy"; difficulty thinking soon after standing up from a sitting or lying position	○	○	○	○
Color changes in your skin, such as red, white or purple	○	○	○	○
Skin rash	○	○	○	○
Episodes of itching and/or hives	○	○	○	○
Episodes of severe allergic reaction (anaphylaxis), with or without any known trigger	○	○	○	○
Excessively dry eyes	○	○	○	○
Excessively dry mouth	○	○	○	○
Excessive thirst	○	○	○	○
Vision problems (blurry, light sensitivity, difficulty reading or focusing, floaters, flashing lights, "snow")	○	○	○	○
Problems with hearing (hearing loss, ringing in ears)	○	○	○	○
Hair loss	○	○	○	○
Problems with teeth	○	○	○	○
Changes to menstrual cycle	○	○	○	○

Changes to menopause symptoms (such as hot flashes)	◯	◯	◯	◯
Changes in fertility or difficulty getting pregnant	◯	◯	◯	◯
Changes in desire for, comfort with or capacity for sex	◯	◯	◯	◯

Have you experienced any other symptoms [stem_attribute]?

◯ Yes
◯ No
◯ I prefer not to answer

Please specify any other symptoms [stem_attribute]:

_section collection language

_____

_section collection language

_____

This set of questions is about fatigue.

How much does your fatigue bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you been fatigued?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you were fatigued, how severe was the fatigue?

◯ Fatigue not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

_____

This set of questions is about post-exertional malaise.

How much does your post-exertional malaise bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you experienced post-exertional malaise?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had post-exertional malaise, how severe was it?

◯ Post-exertional malaise not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

_____

This set of questions is about next day soreness or fatigue after non-strenuous, everyday activities.

How much does your soreness or fatigue after non-strenuous, everyday activities bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had next day soreness or fatigue after non-strenuous, everyday activities?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had next day soreness or fatigue after everyday activites, how severe was it?

◯ Next day soreness or fatigue not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about fever, chills, sweats (flu-like symptoms) or flushing.

How much do your fever, chills, sweats (flu-like symptoms) bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had flu-like symptoms?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had flu-like symptoms, how severe were they?

◯ Flu-like symptoms not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

How much does your flushing bother you (a sudden feeling of warmth and reddening of the face)?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had episodes of flushing?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had episodes of flushing, how severe were they?

◯ No flushing episodes
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about feeling hot or cold for no reason.

How much does feeling hot or cold for no reason bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you felt hot or cold for no reason?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you felt hot or cold for now reason, how severe was it?

◯ Feeling hot or cold for no reason not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about cold limbs.

How much does having cold limbs bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had cold limbs (e.g. arms, legs, hands)?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had cold limbs, how severe was it?

◯ Cold limbs not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about loss of or change in smell or taste.

How much does your loss of or change in smell or taste bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about some smells, foods, medications, or chemicals making you feel sick.

How much does having some smells, foods, medications, or chemicals making you feel sick bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have some smells, foods, medications, or chemicals made you feel sick?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when smells, foods, medications, or chemicals made you feel sick, how severe was it?

◯ These did not make me feel sick
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your runny nose (allergic rhinitus) or sinus problems.

How much does having a runny nose or sinus problems bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your headaches:

How much do your headaches bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had headaches?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had headaches, how severe were they?

◯ No headaches
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

	Never	Rarely	Sometimes	Very often	Always
When you have headaches, how often is the pain severe?	○	○	○	○	○
How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?	○	○	○	○	○
When you have a headache, how often do you wish you could lie down?	○	○	○	○	○
In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?	○	○	○	○	○
In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?	○	○	○	○	○
In the past 4 weeks, how often have you felt fed up or irritated because of your headaches	○	○	○	○	○

_section collection language

You have told us that you have pain in part of your body, or some level of pain in the last 7 days. This set of questions is about your pain.

In the YEAR BEFORE [stem_your], where were you having pain? Check all that apply.

- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat
- ☐ Head pain/headache

AROUND [stem_your], where were you having pain? Check all that apply.

- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat
- ☐ Head pain/headache

BETWEEN 30 DAYS AFTER [stem_your] AND NOW where were you having pain? Check all that apply

- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat
- ☐ Head pain/headache

In [stem_the], where were you having pain that you no longer have? Check all that apply.

- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat
- ☐ Head pain/headache

Where have you had pain in the last 30 days? Check all that apply.

- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat
- ☐ Head pain/headache

_section collection language

_____

This set of questions is about your chest pain.

How much does your chest pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

The following is a list of activities that people often do during the week. Although for some people with several medical problems it is difficult to determine what it is that limits them, please go over the activities listed below and indicate how much limitation you have had due to chest pain, chest tightness, or angina over the past 4 weeks.

	Extremely limited	Quite a bit limited	Moderately limited	Slightly limited	Not at all limited	Limited for other reasons or did not do the activity
Walking indoors on level ground	◯	◯	◯	◯	◯	◯
Gardening, vacuuming, or carrying groceries	◯	◯	◯	◯	◯	◯
Lifting or moving heavy objects (e.g. furniture, children)	◯	◯	◯	◯	◯	◯

Over the past 4 weeks, on average, how many times have you had chest pain, chest tightness, or angina?

◯ 4 or more times per day
◯ 1-3 times per day
◯ 3 or more times per week but not every day
◯ 1-2 times per week
◯ Less than once a week
◯ None over the past 4 weeks

Over the past 4 weeks, on average, how many times have you had to take nitroglycerin (tablets or spray) for your chest pain, chest tightness, or angina?

◯ 4 or more times per day
◯ 1-3 times per day
◯ 3 or more times per week but not every day
◯ 1-2 times per week
◯ Less than once a week
◯ None over the past 4 weeks

Over the past 4 weeks, how much has your chest pain, chest tightness, or angina limited your enjoyment of life?

◯ It has extremely limited my enjoyment of life
◯ It has limited my enjoyment of life quite a bit
◯ It has moderately limited my enjoyment of life
◯ It has slightly limited my enjoyment of life
◯ It has not limited my enjoyment of life at all

If you had to spend the rest of your life with your chest pain, chest tightness, or angina the way it is right now, how would you feel about this?

◯ Not satisfied at all
◯ Mostly dissatisfied
◯ Somewhat satisfied
◯ Mostly satisfied
◯ Completely satisfied

_section collection language

This question is about your abdominal (belly) pain.

How much does your abdominal (belly) pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

In the past year, have you had a cramping or colicky abdominal pain?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past three months, have you had a cramping or colicky abdominal pain?

◯ Never
◯ Sometimes
◯ A lot of the time

How severe are these episodes of cramping or colicky abdominal pain?

◯ Not at all
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

This set of questions is about your pelvic or genital pain.

How much does your pelvic or genital pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your joint pain.

How much does your joint pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had joint pain?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had joint pain, how severe was it?

◯ No joint pain
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your muscle pain.

How much does your muscle pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had pain or aching in your muscles?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had pain or aching in your muscles, how severe was it?

◯ Pain or aching in the muscles not present
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your back or spinal pain.

How much does your back or spinal pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your skin pain.

How much does your skin pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your foot pain.

How much does your foot pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your mouth pain.

How much does your mouth pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your throat pain.

How much does your throat pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about shortness of breath.

How much does your shortness of breath bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Which of the following best describes your shortness of breath?

◯ I only get breathless with strenuous exercise.
◯ I get short of breath when hurrying on the level or walking up a slight hill.
◯ I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level.
◯ I stop for breath after walking about 100 meters or after a few minutes on level ground.
◯ I am too breathless to leave the house or I am breathless when dressing or undressing.

_section collection language

This set of questions is about wheezing or whistling in your chest.

How much does your wheezing or whistling in your chest bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about persistent (chronic) cough.

How much does your persistent (chronic) cough bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about palpitations, racing heart, arrhythmia, skipped beats.

How much do your palpitations, racing heart, arrhythmia, or skipped beats bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about swelling of your legs.

How much does the swelling of your legs bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your nerve problems.

In the YEAR BEFORE [stem_your], which nerve problems did you have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

AROUND [stem_your], which nerve problems did you have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

BETWEEN 30 DAY AFTER [stem_your] AND NOW, which nerve problems did you have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

In [stem_the], which nerve problems did you have that you no longer have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

Which nerve problems have you had in the last 30 days? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

This set of questions is about your tremors.

How much do your tremors bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your abnormal movements.

How much do your abnormal movements bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about weakness in your arms or legs, or with numbness and tingling.

How much does your nerve numbness, tingling, or burning bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check yes or no based on how you usually feel. Thank you.

	Yes	No
Are your legs and/or feet numb?	◯	◯
Do you ever have any burning pain in your legs and/or feet?	◯	◯
Are your feet too sensitive to touch?	◯	◯
Do you get muscle cramps in your legs and/or feet?	◯	◯
Do you ever have any prickling feelings in your legs or feet?	◯	◯
Does it hurt when the bed covers touch your skin?	◯	◯
When you get into the tub or shower, are you able to tell the hot water from the cold water?	◯	◯
Have you ever had an open sore on your foot?	◯	◯
Has your doctor ever told you that you have diabetic neuropathy?	◯	◯
Do you feel weak all over most of the time?	◯	◯
Are your symptoms worse at night?	◯	◯
Do your legs hurt when you walk?	◯	◯
Are you able to sense your feet when you walk?	◯	◯
Is the skin on your feet so dry that it cracks open?	◯	◯
Have you ever had an amputation?	◯	◯

How much does the weakness in your arms or legs bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	◯	◯	◯	◯	◯
Are you able to go up and down stairs at a normal pace?	◯	◯	◯	◯	◯
Are you able to go for a walk of at least 15 minutes?	◯	◯	◯	◯	◯
Are you able to run errands and shop?	◯	◯	◯	◯	◯
Are you able to turn a key in a lock?	◯	◯	◯	◯	◯
Are you able to brush your teeth?	◯	◯	◯	◯	◯
Are you able to make a phone call using a touch tone key-pad?	◯	◯	◯	◯	◯
Are you able to pick up coins from a table top?	◯	◯	◯	◯	◯
Are you able to write with a pen or pencil?	◯	◯	◯	◯	◯
Are you able to open and close a zipper?	◯	◯	◯	◯	◯
Are you able to wash and dry your body?	◯	◯	◯	◯	◯
Are you able to shampoo your hair?	◯	◯	◯	◯	◯

_section collection language

_____

_section collection language

_____

This set of questions is about your seizures.

How much do your seizures bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about problems with thinking or concentrating ("brain fog").

How much do your problems thinking or concentrating ("brain fog") bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had problems remembering things?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had problems remembering things, how severe was it?

◯ No problems remembering things
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

In the past 7 days:

	Never	Rarely (once)	Sometimes (2-3 times)	Often (once a day)	Very often (several times a day)
I had to read something several times to understand it:	◯	◯	◯	◯	◯
My thinking was slow:	◯	◯	◯	◯	◯
I had to work really hard to pay attention or I would make a mistake:	◯	◯	◯	◯	◯
I had trouble concentrating:	◯	◯	◯	◯	◯

How much difficulty do you currently have:

	None	A little	Somewhat	A lot	Cannot do
reading and following complex interactions (e.g., directions for a new medication)?	◯	◯	◯	◯	◯
planning for and keeping appointments that are not part of your weekly routine (e.g. a therapy or doctor appointment, or a social gather with friends and family)?	◯	◯	◯	◯	◯
managing your time to do most of your daily activities?	◯	◯	◯	◯	◯
learning new tasks or instructions?	◯	◯	◯	◯	◯
concentrating?	◯	◯	◯	◯	◯

_section collection language

This set of questions is about your sleep.

How much do your sleep problems bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Has anyone ever told you that you have sleep apnea (stopping breathing during sleep) or that you snore 3 or more times a week?

◯ Yes
◯ No
◯ Prefer not to answer

Have you been told by a doctor to use a pressure machine (e.g. PAP, CPAP, BiPAP) or dental device for your sleep problem?

◯ Yes
◯ No
◯ Prefer not to answer

In the past 7 days...

	Very poor	Poor	Fair	Good	Very good
My sleep quality was	◯	◯	◯	◯	◯

In the past 7 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was refreshing	◯	◯	◯	◯	◯
I had a problem with my sleep	◯	◯	◯	◯	◯
I had difficulty falling asleep	◯	◯	◯	◯	◯
My sleep was restless	◯	◯	◯	◯	◯
I tried hard to get to sleep	◯	◯	◯	◯	◯
I worried about not being able to fall asleep	◯	◯	◯	◯	◯
I was satisfied with my sleep	◯	◯	◯	◯	◯

In the past 7 days, my sleep was refreshing:

◯ None of the time
◯ A little of the time
◯ About half of the time
◯ Most of the time
◯ All of the time

_section collection language

_____

This set of questions is about your vision.

How much do your vision problems bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

This set of questions is about vision problems.

In the past year, without sunglasses or tinted glasses, has bright light bothered your eyes?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past three months, without sunglasses or tinted glasses, has bright light bothered your eyes?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

How severe is this sensitivity to bright light?

◯ Mild
◯ Moderate
◯ Severe

In the past year, have you had trouble focusing your eyes?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past three months, have you had trouble focusing your eyes?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

How severe is this focusing problem?

◯ Mild
◯ Moderate
◯ Severe

Is the most troublesome symptom with your eyes (ie, sensitivity to bright light or trouble focusing) getting:

◯ I have not had any of these symptoms
◯ Much worse
◯ Somewhat worse
◯ Staying about the same
◯ Somewhat better
◯ Much better
◯ Completely gone

_section collection language

_____

At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

◯ Excellent
◯ Good
◯ Fair
◯ Poor
◯ Very Poor
◯ Completely Blind

How much of the time do you worry about your eyesight?

◯ None of the time
◯ A little of the time
◯ Some of the time
◯ Most of the time
◯ All of the time

How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

◯ None
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe

How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

How much difficulty do you have reading street signs or the names of stores?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Are you currently driving, at least once in a while?

◯ Yes
◯ No

Have you never driven a car or have you given up driving?

◯ Never drove
◯ Gave up

Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

◯ Mainly eyesight
◯ Mainly other reasons
◯ Both eyesight and other reasons

How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty

How much difficulty do you have driving at night? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Have you stopped doing this because of your eyesight
◯ Have you stopped doing this for other reasons or are you not interested in doing this

How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Have you stopped doing this because of your eyesight
◯ Have you stopped doing this for other reasons or are you not interested in doing this

The next questions are about how things you do may be affected by your vision. For each one, please indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

Do you accomplish less than you would like because of your vision?

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time

Are you limited in how long you can work or do other activities because of your vision?

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time

How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time

For each of the following statements, please indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

I stay home most of the time because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I feel frustrated a lot of the time because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I have much less control over what I do, because of my eyesight.

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

Because of my eyesight, I have to rely too much on what other people tell me

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I need a lot of help from others because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I worry about doing things that will embarrass myself or others, because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

_section collection language

_____

This set of questions is about skin rash.

How much does your skin rash bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about itching or hives.

How much does itching bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had episodes of itching?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had episodes of itching, how severe were they?

◯ No itching
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

How much do hives (skin redness or swelling) bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Throughout the past month, how often have you had episodes of hives?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

Throughout the past month, when you had episodes of hives, how severe were they?

◯ No hives
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about severe allergic reactions (anaphylaxis).

How much do your severe allergic reactions bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your excessive thirst.

How much does your excessive thirst bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about problems with hearing (hearing loss, ringing in ears).

How much do your problems with hearing (hearing loss or ringing in ears) bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about hair loss.

How much does your hair loss bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about your problems with teeth.

How much do your problems with teeth bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about feeling faint, dizzy or goofy.

How much does feeling faint, dizzy, or goofy bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

When standing up, how frequently do you get these feelings or symptoms?

◯ Rarely
◯ Occasionally
◯ Frequently
◯ Almost always

How would you rate the severity of these feelings or symptoms?

◯ Mild
◯ Moderate
◯ Severe

In the past year, have these feelings or symptoms that you have experienced:

◯ Gotten much worse
◯ Gotten somewhat worse
◯ Stayed about the same
◯ Gotten somewhat better
◯ Gotten much better
◯ Completely gone

In the past three months, have these feelings or symptoms that you have experienced:

◯ Gotten much worse
◯ Gotten somewhat worse
◯ Stayed about the same
◯ Gotten somewhat better
◯ Gotten much better
◯ Completely gone

_section collection language

_____

This set of questions is about changes in skin color.

How much does the change in your skin color bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

What parts of your body are affected by these color changes? (check all that apply)

☐ Hands
☐ Feet

Are these changes in your skin color:

◯ Getting much worse
◯ Getting somewhat worse
◯ Staying about the same
◯ Getting somewhat better
◯ Getting much better
◯ Completely gone

This set of questions is about changes in sweating.

In the past 5 years, what changes, if any, have occurred in your general body sweating?

◯ I sweat much more than I used to
◯ I sweat somewhat more than I used to
◯ I haven't noticed any changes in my sweating
◯ I sweat somewhat less than I used to
◯ I sweat much less than I used to

In the past three months, what changes, if any, have occurred in your general body sweating?

◯ I sweat much more than I used to
◯ I sweat somewhat more than I used to
◯ I haven't noticed any changes in my sweating
◯ I sweat somewhat less than I used to
◯ I sweat much less than I used to

This set of questions is about dry eyes and mouth.

Do your eyes feel excessively dry?

◯ Yes
◯ No

_section collection language

This set of questions is about having an excessively dry mouth.

How much do your excessively dry eyes bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

How much does your excessively dry mouth bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

For the symptom of dry mouth that you had had for the longest period of time, is this symptom:

◯ I have not had any of these symptoms
◯ Getting much worse
◯ Getting somewhat worse
◯ Staying about the same
◯ Getting somewhat better
◯ Getting much better
◯ Completely gone

For the symptom of dry eyes or dry mouth that you had had for the longest period of time, is this symptom:

◯ I have not had any of these symptoms
◯ Getting much worse
◯ Getting somewhat worse
◯ Staying about the same
◯ Getting somewhat better
◯ Getting much better
◯ Completely gone

_section collection language

This set of questions is about belly problems.

How much do your belly symptoms bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

In the past three months, how often had you had reflux or heartburn?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

How much does the reflux or heartburn bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

When you had reflux or heartburn, how severe was it?

◯ No reflux or heartburn
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

In the past three months, how often have you been nauseated (felt like you wanted to throw up)?

◯ None of the time
◯ A little of the time
◯ About half the time
◯ Most of the time
◯ All of the time
◯ I don't know or prefer not to answer

How much does the nausea bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

When you were nauseated, how severe was it?

◯ No nausea
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

In the past year, have you noticed any changes in how quickly you get full when eating a meal?

◯ I get full a lot more quickly than I used to
◯ I get full more quickly than I used to
◯ I haven't noticed any change
◯ I get full less quickly than I used to
◯ I get full a lot less quickly than I used to

In the past three months, have you noticed any changes in how quickly you get full when eating a meal?

◯ I get full a lot more quickly than I used to
◯ I get full more quickly than I used to
◯ I haven't noticed any change
◯ I get full less quickly than I used to
◯ I get full a lot less quickly than I used to

In the past year, have you felt excessively full or persistently full (bloated feeling) after a meal?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past three months, have you felt excessively full or persistently full (bloated feeling) after a meal?

◯ Never
◯ Sometimes
◯ A lot of the time

When you felt bloated, how severe was it?

◯ Did not feel bloated
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

How much does this feeling of being full (bloated) bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

In the past year, have you ever vomited after a meal?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past three months, have you ever vomited after a meal?

◯ Never
◯ Sometimes
◯ A lot of the time

How much does this vomiting bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

In the past year, have you had a cramping or colicky abdominal pain?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past three months, have you had a cramping or colicky abdominal pain?

◯ Never
◯ Sometimes
◯ A lot of the time

How severe are these episodes of crampy abdominal pain?

◯ Not at all
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe
◯ I don't know or prefer not to answer

How much does this cramping or colicky abdominal pain bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

In the past year, have you had any bouts of diarrhea?

◯ Yes
◯ No

In the past three months, have you had any bouts of diarrhea?

◯ Yes
◯ No

How much does the diarrhea bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

How frequently does this diarrhea occur?

◯ Rarely
◯ Occasionally
◯ Frequently
◯ Constantly

How severe are these bouts of diarrhea?

◯ Mild
◯ Moderate
◯ Severe

Are your bouts of diarrhea getting:

◯ Much worse
◯ Somewhat worse
◯ Staying the same
◯ Somewhat better
◯ Much better
◯ Completely gone

In the past year, have you been constipated?

◯ Yes
◯ No

In the past three months, have you been constipated?

◯ Yes
◯ No

How much does the constipation bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

How frequently are you constipated?

◯ Rarely
◯ Occasionally
◯ Frequently
◯ Constantly

How severe are these episodes of constipation?

◯ Mild
◯ Moderate
◯ Severe

Is your constipation getting:

◯ Much worse
◯ Somewhat worse
◯ Staying the same
◯ Somewhat better
◯ Much better
◯ Completely gone

_section collection language

_____

This set of questions is about bladder problems.

In the past year, have you ever lost control of your bladder function?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past three months, have you ever lost control of your bladder function?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past year, have you had difficulty passing urine?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past three months, have you had difficulty passing urine?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past year, have you had trouble completely emptying your bladder?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past three months, have you had trouble completely emptying your bladder?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

How much do your bladder problems bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

_section collection language

This set of questions is about the changes to your menstrual cycle.

How much do the changes to your menstrual cycle bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Are your periods:

◯ More frequent
◯ Less frequent
◯ About the same frequency

Is the bleeding during your period:

◯ Heavier
◯ Lighter
◯ About the same

_section collection language

This set of questions is about the changes to your menopause symptoms.

How much do the changes to your menopause symptoms bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Have your hot flashes become more frequent?

◯ Yes
◯ No

_section collection language

_____

This set of questions is about your changes in fertility or difficulty getting pregnant.

How much do the changes in your fertility or difficulty getting pregnant bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

Have you had any treatment for infertility including medications or procedures such as IVF?

◯ Yes
◯ No

_section collection language

_____

This set of questions is about your changes in desire for, comfort with, or capacity for sex.

How much do your changes in desire for, comfort with, or capacity for sex bother you?

◯ Not at all
◯ A little bit
◯ Somewhat
◯ Quite a bit
◯ Very much
◯ I don't know or prefer not to answer

These questions ask about your sexual feelings and responses DURING THE PAST 4 WEEKS. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential.

During the past 4 weeks, how satisfied were you with the frequency of your sexual activity (with or without a partner)?

◯ Very satisfied
◯ Somewhat satisfied
◯ Neither satisfied nor dissatisfied
◯ Somewhat dissatisfied
◯ Very dissatisfied

During the past 4 weeks, how satisfied in general have you been with your ability to have and enjoy sex (with or without a partner)?	◯ Very satisfied ◯ Somewhat satisfied ◯ Neither satisfied nor dissatisfied ◯ Somewhat dissatisfied ◯ Very dissatisfied ◯ I don't have a partner/I don't have sex without a partner
During the past 4 weeks, when you had sexual activity, how much of the time did you experience orgasm?	◯ Never ◯ Rarely ◯ Sometimes ◯ Most of the time ◯ All of the time ◯ I did not have sexual activity
During the past 4 weeks, when you had sexual activity, how much of the time did you feel satisfied after sexual activity?	◯ Never ◯ Rarely ◯ Sometimes ◯ Most of the time ◯ All of the time ◯ I did not have sexual activity
During the past 4 weeks, when you experienced orgasm, how strong or intense was the orgasm on average?	◯ Did not experience any orgasms ◯ Mild ◯ Moderate ◯ Strong
During the past 4 weeks, how much of a problem was difficulty in having an orgasm?	◯ Not a problem ◯ Little of a problem ◯ Somewhat of a problem ◯ Very much of a problem ◯ I did not have sexual activity
During the past 4 weeks, how much of a problem was lack of sexual interest?	◯ Not a problem ◯ Little of a problem ◯ Somewhat of a problem ◯ Very much of a problem ◯ I did not have sexual activity
During the past 4 weeks, how often did you desire sex (with or without a partner?)	◯ Never ◯ Once or twice ◯ 3-4 times ◯ 5-6 times ◯ More than 6 times
During the past 4 weeks, how much of a problem was inability to relax and enjoy sex?	◯ Not a problem ◯ Little of a problem ◯ Somewhat of a problem ◯ Very much of a problem ◯ I did not have sexual activity
During the past 4 weeks, to what extent has your bleeding interfered with your normal or regular sexual activity (with or without a partner)?	◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

During the past 4 weeks, to what extent has your pelvic pain or discomfort interfered with your normal or regular sexual activity (with or without a partner)?

◯ Not at all
◯ Slightly
◯ Moderately
◯ Quite a bit
◯ Extremely

During the past 4 weeks, to what extent have your pelvic problems overall interfered with your normal or regular sexual activity (with or without a partner)?

◯ Not at all
◯ Slightly
◯ Moderately
◯ Quite a bit
◯ Extremely

How would you rate each of the following during the last 4 weeks?

Your level of sexual desire?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

Your ability to have an erection?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

Your ability to reach orgasm (climax)?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

How would you describe the usual quality of your erections?

◯ None at all
◯ Not firm enough for any sexual activity
◯ Firm enough for masturbation and foreplay only
◯ Firm enough for intercourse

How would you describe the frequency of your erections?

◯ I never had an erection when I wanted one
◯ I had an erection less than half the time I wanted one
◯ I had an erection about half the time I wanted one
◯ I had an erection more than half the time I wanted one
◯ I had an erection whenever I wanted one

How often have you awakened in the morning or night with an erection?

◯ Never
◯ Seldom (less than 25% of the time)
◯ Not often (less that half the time)
◯ Often (more than half the time)
◯ Very often (more than 75% of the time)

During the last 4 weeks did you have vaginal or anal intercourse?

◯ No
◯ Yes, once
◯ Yes, more than once

Overall, how would you rate your ability to function sexually during the last 4 weeks?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

_section collection language

_____

Over the past two weeks, how often have you been bothered by the following problems:

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things:	◯	◯	◯	◯
Feeling down, depressed, or hopeless:	◯	◯	◯	◯
Trouble falling or staying asleep, or sleeping too much:	◯	◯	◯	◯
Feeling tired or having little energy:	◯	◯	◯	◯
Poor appetite or overeating:	◯	◯	◯	◯
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down:	◯	◯	◯	◯
Trouble concentrating on things, such as reading the newspaper or watching television:	◯	◯	◯	◯
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual:	◯	◯	◯	◯

Thoughts that you would be better off dead, or of hurting yourself:	◯	◯	◯	◯

In the past month, have you actually had any thoughts of killing yourself?

◯ Yes
◯ No

In the past 3 months, have you ever done anything, started to do anything, or prepared to do anything to end your life?

◯ Yes
◯ No

You indicated that you had thoughts of hurting yourself in some way in the past month. If you feel you may act on these thoughts there are crisis services that can help including calling, texting, or chatting 988, going to your local emergency room, or contacting a dedicated suicide prevention resource such as the services listed below and contact your own mental health provider if you are in care: 24/7 Crisis Hotline: 988 Suicide and Crisis Lifeline
https://988lifeline.org/
or 1-800-273-TALK (8255) (Veterans, press 1)
or call/text/chat 988Crisis Text Line
http://wwcrisistextline.org
Text TALK to 741-741 to text with a trained crisis counselor from the Crisis Text Line for free, 24/7Veterans Crisis Line
https://www.veteranscrisisline.net
Send a text to 838255Please note a member of the study team may call you to follow up in the coming days but this is not a replacement for clinical care or emergency services.

_section collection language

Over the past two weeks, how often have you been bothered by the following problems:

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge:	◯	◯	◯	◯
Not being able to stop or control worrying:	◯	◯	◯	◯
Worrying too much about different things:	◯	◯	◯	◯
Trouble relaxing:	◯	◯	◯	◯
Being so restless that it is hard to sit still:	◯	◯	◯	◯
Becoming easily annoyed or irritable:	◯	◯	◯	◯
Feeling afraid as if something awful might happen:	◯	◯	◯	◯

_section collection language

Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else?

☐ No
☐ Yes before [stem_my]
☐ Yes after [stem_my]

In [stem_the], have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else?

◯ Yes
◯ No
◯ I prefer not to answer

In the past month, have you had nightmares about the event(s) or thought about the event(s) when you did not want to?

◯ Yes
◯ No

In the past month, have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

◯ Yes
◯ No

In the past month, have you been constantly on guard, watchful, or easily startled?

◯ Yes
◯ No

In the past month, have you felt numb or detached from people, activities, or your surroundings?

◯ Yes
◯ No

In the past month, have you felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

◯ Yes
◯ No

_section collection language

_____

Have you lost someone significant to you [stem_sincein]?

◯ Yes
◯ No

Was it due to COVID?

◯ Yes
◯ No

What was your relationship to the person who died? If you have lost more than one person, please answer based on the most recent loss.

◯ Parent
◯ Child
◯ Significant other
◯ Sibling
◯ Friend/colleague or acquaintance
◯ Other

How many months has it been since this death?

_____
(Months)

Have you been experiencing persistent distressing grief with yearning and/or feeling life is empty since this death?

◯ Yes
◯ No

Is grief currently your most distressing problem?

◯ Yes
◯ No
◯ Prefer not to answer

_section collection language

_____

Have you been to the hospital [stem_sincein]? Check all that apply.

☐ Yes, I visited the emergency department
☐ Yes, I was admitted to the hospital
☐ No

_section collection language

_____

Pregnancy

Pregnancy form version:

_____

Placeholder to attach form-level queries

_____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Error: this form should only be collected for participants who have a biological birth sex of female. Please cancel out of this instrument; do not save it.

Date of Pregnancy form collection:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language

_____

Have you ever been pregnant?

◯ Yes
◯ No
◯ Prefer not to answer

How many times have you been pregnant (including your current/recent pregnancy, previous pregnancies, live births, miscarriages, stillbirths or abortions)?

_____

How many of your pregnancies resulted in the live birth of a baby? (Enter '0' if not applicable)

_____

How many of your pregnancies resulted in a miscarriage? (Enter '0' if not applicable)

_____

How many of your pregnancies resulted in an abortion? (Enter '0' if not applicable)

_____

How many of your pregnancies resulted in a stillbirth (the death of the fetus at more than 20 weeks (5 months) of pregnancy)? (Enter '0' if not applicable)

_____

Note: you have more births, miscarriages, abortions, and stillbirths listed than total pregnancies. Please check that your numbers are correct.

During any pregnancy BEFORE [stem_your], did you ever have any of these conditions:

☐ Diabetes (high blood sugars), pregnancy related (sometimes called gestational diabetes)
☐ High blood pressure, pregnancy related (sometimes called gestational hypertension)
☐ Preeclampsia (sometimes called "toxemia")
☐ HELLP syndrome (abnormal liver function and changes in blood platelet counts, often also with high blood pressure)
☐ Preterm birth (baby born more than 3 weeks before the due date)
☐ I did not have any of these conditions
☐ I did not have any pregnancies BEFORE [stem_my]
☐ I prefer not to answer

Are you currently pregnant?

◯ Yes
◯ No
◯ I prefer not to answer

Were you pregnant on [visit_qinfdt]?

◯ Yes
◯ No
◯ I prefer not to answer

When you were pregnant around [stem_your], how did the pregnancy end?

◯ Live birth of a baby or babies
◯ Abortion
◯ Miscarriage
◯ Ectopic pregnancy
◯ Molar pregnancy
◯ Stillbirth (Death of a fetus >20 weeks (5 months) of pregnancy)
◯ Still pregnant
◯ I prefer not to answer

How far along in the pregnancy were you when you had the abortion?

_____
((in weeks from last menstrual period))

We are very sorry to hear about your loss. We have just one more question so that we can learn more about miscarriage and COVID.

How far along in the pregnancy were you when the miscarriage occurred?

_____
((in weeks from last menstrual period))

We are very sorry to hear about your loss. We have just one more question so that we can learn more about stillbirth and COVID.

How far along in the pregnancy were you when the stillbirth (fetal death) occurred?

_____
(weeks)

These questions are about your pregnancy around [visit_qinfdt].

For your pregnancy around [visit_qinfdt], what was the due date for the pregnancy?

_____
(Leave blank if you don't remember the due date.)

For your pregnancy around [visit_qinfdt], what was the actual date of birth of the baby?

_____
(Leave blank if you don't remember the actual date of birth.)

For your pregnancy around [visit_qinfdt], did you have any of the following conditions (check all that apply):

☐ Diabetes, pregnancy related (gestational diabetes)
☐ High blood pressure, pregnancy related (gestational hypertension)
☐ Preeclampsia (sometimes called "toxemia")
☐ HELLP syndrome (abnormal liver function and low blood platelet levels, often also with high blood pressure)
☐ Seizures
☐ Placenta abruption (when the placenta separates off from the uterus)
☐ Preterm premature rupture of membranes (when the bag of water breaks at a time when the baby would be born premature, eg. before 37 weeks of pregnancy)
☐ Low amniotic fluid levels (oligohydramnios)
☐ Other (specify)
☐ None
☐ I prefer not to answer

Other, please specify:

_____

For your pregnancy around [visit_qinfdt], did you receive a steroid shot during pregnancy to get your baby ready for an early delivery (medication called betamethasone or dexamethasone)?

◯ Yes
◯ No
◯ Prefer not to answer

Did your COVID illness result in your doctor or midwife delivering the baby before you had planned to deliver?

◯ Yes
◯ No
◯ Prefer not to answer

For your pregnancy around [visit_qinfdt], did you have any of the following conditions during or after the birth (check all that apply)

☐ Hemorrhage or excessive bleeding
☐ Blood transfusion
☐ Uterine infection (also called chorioamnionitis or endometritis) during or after the birth
☐ Blood clot in the legs or lungs requiring treatment with blood thinning medications
☐ Other (please explain below):
☐ None
☐ I prefer not to answer

Other, please specify:

_____

These questions are about the baby/babies born following the pregnancy around [visit_qinfdt].

What is the name of the hospital or facility where your baby was born and what city is in in?

_____

How many babies were born?

_____

Was your baby born by:

◯ Vaginal delivery
◯ Cesarean delivery
◯ Prefer not to answer

Was a vacuum (suction cup) or forceps used to deliver the baby?

◯ Yes
◯ No
◯ I don't know
◯ Prefer not to answer

What was the reason you had a cesarean delivery?

☐ Planned cesarean delivery because I had a prior cesarean delivery
☐ Abnormal progress in labor
☐ Concern about your baby based on the heart monitor
☐ Baby was breech
☐ Uterine infection
☐ Emergency due to risk to baby or myself
☐ I was too sick with COVID to be in labor
☐ Other, please explain below
☐ I prefer not to answer

This is about the first child in this pregnancy.

What is the baby's sex?

◯ Male
◯ Female
◯ Intersex

How much did the baby weigh at birth?Pounds:Ounces{preg_covidwtlb_1:icons}{preg_covidwtoz_1:icons}

Did the baby have a birth defect (congenital anomaly)?

◯ Yes
◯ No
◯ Prefer not to answer

What type of birth defect did your baby have?

☐ Cardiac (heart)
☐ Lungs (pulmonary)
☐ Abdomen (sometimes called gastroschisis or omphalocele)
☐ Kidneys (renal)
☐ Bladder
☐ Limbs (extremities)
☐ Brain
☐ Face or lip (sometimes called cleft lip or palate)
☐ Prefer not to answer

Was your baby admitted to the neonatal intensive care unit (NICU)?

◯ Yes
◯ No
◯ Prefer not to answer

What is the name of the hospital and city where your baby was admitted to the NICU?

_____

Is this baby that you delivered following your pregnancy around [visit_qinfdt] still living?

◯ Yes
◯ No
◯ Prefer not to answer

We are very sorry to hear about your loss. We have just one more question for you.

Did your baby survive until they could be discharged home from the hospital after delivery?

◯ Yes
◯ No
◯ Prefer not to answer

This is about the second child in this pregnancy.

What is the baby's sex?

◯ Male
◯ Female
◯ Intersex

How much did the baby weigh at birth?
Pounds:Ounces{preg_covidwtlb_2:icons}{preg_covidwtoz_2:icons}

Did the baby have a birth defect (congenital anomaly)?

◯ Yes
◯ No
◯ Prefer not to answer

What type of birth defect did your baby have?

☐ Cardiac (heart)
☐ Lungs (pulmonary)
☐ Abdomen (sometimes called gastroschisis or omphalocele)
☐ Kidneys (renal)
☐ Bladder
☐ Limbs (extremities)
☐ Brain
☐ Face or lip (sometimes called cleft lip or palate)
☐ Prefer not to answer

Was your baby admitted to the neonatal intensive care unit (NICU)?

◯ Yes
◯ No
◯ Prefer not to answer

What is the name of the hospital and city where your baby was admitted to the NICU?

_____

Is this baby that you delivered following your pregnancy around [visit_qinfdt] still living?

◯ Yes
◯ No
◯ Prefer not to answer

We are very sorry to hear about your loss. We have just one more question for you.

Did your baby survive until they could be discharged home from the hospital after delivery?

◯ Yes
◯ No
◯ Prefer not to answer

This is about the third child in this pregnancy.

What is the baby's sex?

◯ Male
◯ Female
◯ Intersex

How much did the baby weigh at birth?
Pounds:Ounces{preg_covidwtlb_3:icons}{preg_covidwtoz_3:icons}

Did the baby have a birth defect (congenital anomaly)?

◯ Yes
◯ No
◯ Prefer not to answer

What type of birth defect did your baby have?

☐ Cardiac (heart)
☐ Lungs (pulmonary)
☐ Abdomen (sometimes called gastroschisis or omphalocele)
☐ Kidneys (renal)
☐ Bladder
☐ Limbs (extremities)
☐ Brain
☐ Face or lip (sometimes called cleft lip or palate)
☐ Prefer not to answer

Was your baby admitted to the neonatal intensive care unit (NICU)?

◯ Yes
◯ No
◯ Prefer not to answer

What is the name of the hospital and city where your baby was admitted to the NICU?

_____

Is this baby that you delivered following your pregnancy around [visit_qinfdt] still living?

◯ Yes
◯ No
◯ Prefer not to answer

We are very sorry to hear about your loss. We have just one more question for you.

Did your baby survive until they could be discharged home from the hospital after delivery?

◯ Yes
◯ No
◯ Prefer not to answer

Have you given birth in the last three months (since [preg_90daysbefore]?)

◯ Yes
◯ No

Recent COVID Treatment

Recent COVID treatment form version: _____

Placeholder to attach form-level queries _____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Error: this participant has not had COVID. This instrument should not be collected. Please choose to cancel the instrument; do not save it.

Error: this participant has not had a new COVID infection. This instrument should not be collected. Please choose to cancel the instrument; do not save it.

Date of COVID Treatment form collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language _____

Please answer the following questions based on the most recent time you got COVID.

What kind of medical care did you get the most recent time you had COVID? Check all that apply.

☐ I had no symptoms
☐ I managed my symptoms at home by myself
☐ I managed my symptoms at home and saw a doctor about it (in person or by telehealth)
☐ I visited the emergency department
☐ I was admitted to the hospital
☐ I don't remember
☐ Prefer not to answer

Were you treated with any of the following during your most recent COVID illness?

	Yes	No	I don't know	I prefer not to answer
Nasal cannula (tube in nose) for oxygen	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?

Treatment with steroids (e.g. dexamethasone, solumedrol, prednisone)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with hydroxychloroquine	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with monoclonal antibody	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with remdesivir	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with other antiviral drug (e.g. lopinavir, ritonavir, nirmatrelvir/ritonavir (Paxlovid), molnupiravir, etc.)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with convalescent plasma	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with anticoagulation (e.g. aspirin, heparin, warfarin (Coumadin), enoxaparin (Lovenox), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc.)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with antibiotics (e.g. azithromycin (Z-pack, Zithromax), levofloxacin (Levoquin), amoxicillin/clavulonic acid (Augmentin), etc.)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with ivermectin	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with fluvoxamine (Luvox)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment in the intensive care unit	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Mechanical ventilation (intubated; placed on a machine to help you breathe through a tube down your throat)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
ECMO (extracorporeal membrane oxygenation, bypass machine for oxygen)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with IL-6 antagonist (e.g. tocilizumab (Actemra), sarilumab (Kevzara), siltuximab (Sylvant), etc.)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with IL-1 antagonist (anakinra (Kineret), canakinumab (Ilaris))	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Treatment with kinase inhibitor (e.g. acalabrutinib (Calquence), ibrutinib (Imbruvica), zanubrutinib (Brukinsa), baricitinib (Olumiant), ruxolitinib (Jakafi), tofacitinib (Xeljanz), etc.)	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
COVID experimental treatment trial	○	○	○	○

Were you treated with any of the following during your most recent COVID illness?				
Other treatment	○	○	○	○

Please specify what other treatment you received: _____

Name of the COVID experimental treatment trial (if known): _____

Date enrolled in [rx2_coenrollname] trial (best estimate): _____

Name of the treatment(s) being tested (if known):

_____

Is (or was) this a randomized trial?

◯ Yes
◯ No
◯ Don't know

Do you know what treatment you are getting (or got)?

◯ Yes
◯ No

Name of treatment, or write "none" if placebo:

_____

Social Determinants of Health

SDOH form version:

_____

Placeholder to attach form-level queries

_____

(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of SDOH data collection:

_____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language

_____

Housing:

_section collection language

_____

How many people live with you?

_____

Are you currently living in transitional housing, staying in a shelter, or experiencing homelessness?

◯ Yes
◯ No
◯ I prefer not to answer

Which best describes the place in which you live?

◯ A one-family house detached from any other house
◯ A townhouse, row house, apartment, or condo of 2-4 units
◯ An apartment or condo with 5-19 units
◯ An apartment or condo with 20 or more units
◯ Nursing home
◯ Residential care for people with intellectual and developmental disabilities
◯ Psychiatric treatment facility
◯ Other group home setting
◯ Foster care
◯ Somewhere else
◯ I prefer not to answer

Marital Status:

_section collection language _____

What is your current marital status?

◯ Married
◯ Divorced
◯ Widowed
◯ Separated
◯ Never Married
◯ Living with partner
◯ I prefer not to answer

Employment:

_section collection language

_____

We would like to know about what you were doing around [stem_your] -- were you working, looking for work, retired, keeping house, a student, or something else?

◯ Working
◯ Only temporarily laid off, sick leave or maternity leave
◯ Looking for work, unemployed
◯ Retired
◯ Disabled, permanently or temporarily
◯ Keeping house
◯ Student
◯ Other (Specify)
◯ I prefer not to answer
◯ I don't know

Please specify other employment status:

_____

Insurance:

_section collection language

_____

Are you currently covered by any of the following types of health insurance or health coverage plans? Select all that apply.

- ☐ Insurance purchased directly from an insurance company (by you or another family member)
- ☐ Insurance through a current or former employer or union (by you or another family member)
- ☐ Medicare, for people 65 or older, or people with certain disabilities
- ☐ Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or disability
- ☐ TRICARE, or other military health care
- ☐ Veteran Affairs (VA) (including those who have ever used or enrolled for VA health care)
- ☐ Indian Health Service
- ☐ I don't have health insurance, self-pay
- ☐ I don't know what kind of health insurance I have
- ☐ I prefer not to answer

Did you lose health insurance coverage because of the COVID pandemic?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Birthplace:

_section collection language

_____

Where were you born?

◯ In the United States or a United States territory
◯ Outside the United States and territories
◯ I prefer not to answer

Please specify which state or territory you were born in:

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ District of Columbia(DC)
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ American Somoa
- ◯ GUAM
- ◯ Northern Mariana Islands
- ◯ Puerto Rico
- ◯ US Virgin Islands

Please specify which foreign country you were born in: _____

Spoken Language:

_section collection language

_____

Is English your primary language?

◯ Yes
◯ No
◯ Prefer not to answer

What language(s)

☐ Spanish
☐ Vietnamese
☐ Mandarin
☐ Cantonese
☐ Tagalog
☐ Hawaiian
☐ Ilocano
☐ Navajo
☐ Russian
☐ Hindi
☐ Haitian Creole
☐ Cape Verdean Creole
☐ Other
☐ Prefer not to answer

Specify other language(s)

_____

Would you say you speak English...

◯ Very well
◯ Well
◯ Not well
◯ Not at all
◯ Prefer not to answer

Family Income:

_section collection language

_____

In 2019, what was your total household income before taxes?

◯ Less than $15,000
◯ $15,000 - $19,999
◯ $20,000 - $24,999
◯ $25,000 - $34,999
◯ $35,000 - $49,999
◯ $50,000 - $74,999
◯ $75,000 - $99,999
◯ $100,000 and above
◯ Prefer not to answer

Household Finances:

_section collection language

_____

Has your household income changed significantly since February 2020?(Please EXCLUDE a stimulus payment from the federal government if you have received one)

◯ Yes, my household income is more
◯ Yes, my household income is less
◯ No, my household income is about the same
◯ Prefer not to answer

In the past month, how difficult has it been for you to cover your expenses and pay all your bills?

◯ Very difficult
◯ Somewhat difficult
◯ Not at all difficult
◯ Don't know
◯ Prefer not to answer

Food Insecurity:

_section collection language

_____

These next questions are about the food eaten in your household in the last 12 months and whether you were able to afford the food you need

Within the past 12 months before [stem_my] we worried whether our food would run out before we got money to buy more.

◯ Often true
◯ Sometimes true
◯ Never true
◯ Prefer not to answer

Within the past 12 months before [stem_my] the food we bought just didn't last and we didn't have money to get more.

◯ Often true
◯ Sometimes true
◯ Never true
◯ Prefer not to answer

Access to Healthcare:

_section collection language

_____

Before [stem_your], about how long had it been since you last saw a doctor or other health care professional about your health?

◯ Within the previous year (less than 12 months ago)
◯ Within the previous two years (1 year but less than 2 years ago)
◯ Within the previous three years (2 years but less than 3 years ago)
◯ Within the previous five years (3 years but less than 5 years ago)
◯ Within the previous ten years (5 years but less than 10 years ago)
◯ Ten years ago or more
◯ I can't remember
◯ I prefer not to answer

Was this a wellness visit, physical, or general purpose check-up?

◯ Yes
◯ No
◯ I don't know
◯ I prefer not to answer

About how long has it been since you last saw a doctor or other health professional for a wellness visit, physical, or general purpose check-up?

◯ Within the previous year (less than 12 months ago)
◯ Within the previous two years (1 year but less than 2 years ago)
◯ Within the previous three years (2 years but less than 3 years ago)
◯ Within the previous five years (3 years but less than 5 years ago)
◯ Within the previous ten years (5 years but less than 10 years ago)
◯ Ten years ago or more
◯ I can't remember
◯ I prefer not to answer

The second question is particularly about the last wellness visit you had, which you indicated was not as recent as the last visit you had. If the answer is correct, ignore this note.

Is there a place that you USUALLY go to if you are sick and need health care?

◯ Yes
◯ There is NO place
◯ There is MORE THAN ONE place
◯ Don't know
◯ I prefer not to answer

What kind of place is it/do you go to most often?

◯ A doctor's office or health center
◯ An urgent care center
◯ A clinic in a drug store or grocery store
◯ A hospital emergency room
◯ A VA Medical Center or VA outpatient clinic
◯ Some other place
◯ Do not go to one place most often
◯ Don't know
◯ Prefer not to answer

During the 12 months before [stem_your], how many times had you gone to an urgent care center or a clinic in a drug store or grocery store about your health?

_____

During the 12 months before [stem_your], how many times had you gone to a hospital emergency room about your health?

_____

During the 12 months before [stem_your], had you been hospitalized overnight?

◯ Yes
◯ No
◯ I don't know
◯ I prefer not to answer

During the 12 months before [stem_your], was there any time when you needed medical care, but DID NOT GET IT because of the cost?

◯ Yes
◯ No
◯ I don't know
◯ I prefer not to answer

Social Support:

_section collection language

_____

If you needed it, how often is someone available...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Prefer not to answer
to help you if you were confined to bed?	○	○	○	○	○	○
to take you to the doctor if you need it?	○	○	○	○	○	○
to prepare your meals if you are unable to do it yourself?	○	○	○	○	○	○
to help with daily chores if you were sick?	○	○	○	○	○	○
to have a good time with?	○	○	○	○	○	○
to turn to for suggestions about how to deal with a personal problem?	○	○	○	○	○	○
who understands your problems?	○	○	○	○	○	○
to love and make you feel wanted?	○	○	○	○	○	○

Community Cohesion:

_section collection language

_____

We are now going to ask you several questions about the neighborhood where you live because sometimes, it can help us understand your health.Please indicate the degree to which you agree or disagree with the below statements.

	Definitely agree	Somewhat agree	Somewhat disagree	Definitely disagree	Prefer not to answer
People in this neighborhood help each other out.	◯	◯	◯	◯	◯
There are people I can count on in this neighborhood.	◯	◯	◯	◯	◯
People in this neighborhood can be trusted.	◯	◯	◯	◯	◯

Discrimination:

_section collection language

_____

In your day-to-day life, how often do any of the following things happen to you?

	Almost every day	At least once a week	A few times a month	A few times a year	Less than once a year	Never	Prefer not to answer
You are treated with less courtesy than other people are.	○	○	○	○	○	○	○
You are treated with less respect than other people are.	○	○	○	○	○	○	○
You receive poorer service than other people at restaurants or stores.	○	○	○	○	○	○	○
People act as if they think you are not smart.	○	○	○	○	○	○	○
People act as if they are afraid of you.	○	○	○	○	○	○	○
People act as if they think you are dishonest.	○	○	○	○	○	○	○
People act as if they're better than you are.	○	○	○	○	○	○	○
You are called names or insulted.	○	○	○	○	○	○	○
You are threatened or harassed.	○	○	○	○	○	○	○
You are discriminated against, hassled, or made to feel inferior while getting medical care.	○	○	○	○	○	○	○

What do you think is the main reason for these experiences?

- ☐ Your Ancestry or National Origins
- ☐ Your Gender
- ☐ Your Race
- ☐ Your Age
- ☐ Your Religion
- ☐ Your Height
- ☐ Your Weight
- ☐ Some other Aspect of Your Physical Appearance
- ☐ Your Sexual Orientation
- ☐ Your Education or Income Level
- ☐ A physical disability
- ☐ Your shade of skin color
- ☐ Your tribe
- ☐ Other
- ☐ Prefer not to answer

Other (please specify)

_____

	Never	Almost never	Sometimes	Fairly often	Very often	Prefer not to answer
In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○	○
In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○	○
In the last month, how often have you felt that things were going your way?	○	○	○	○	○	○
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○	○

Vaccine Status

Vaccine status form version: _____

Placeholder to attach form-level queries _____
(This field cannot be edited and should be blank)

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date Vaccination Questions Completed _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

_form collection language _____

Have you received a COVID vaccine?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

Have you received one or more additional COVID vaccine shots since you last answered the survey?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

{vacc_numb_bltext}{vacc_numb_futext}

_____

For the first shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of first vaccine dose (approximate is acceptable): _____

For the second shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of second vaccine dose (approximate is acceptable): _____

For the third shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of third vaccine dose (approximate is acceptable): _____

For the fourth shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of fourth vaccine dose (approximate is acceptable): _____

For the fifth shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of fifth vaccine dose (approximate is acceptable): _____

For the sixth shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of sixth vaccine dose (approximate is acceptable): _____

For the seventh shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of seventh vaccine dose (approximate is acceptable): _____

For the eighth shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of eighth vaccine dose (approximate is acceptable): _____

For the ninth shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of ninth vaccine dose (approximate is acceptable): _____

For the tenth shot, which vaccine did you have?

◯ Moderna
◯ Pfizer
◯ Johnson and Johnson
◯ Astra Zeneca
◯ Other
◯ Prefer not to answer

Please specify: _____

Date of tenth vaccine dose (approximate is acceptable): _____