June 23, 2022

# Long Haul COVID questionnaire

## Introduction

Thanks for taking time to complete the follow-up survey for the CHASING COVID Cohort study. This should take 15-20 minutes of your time. When you finish the survey, you'll be directed to resources with accurate and up-to-date information about the new coronavirus. This survey may look a little different from previous surveys. The aim of today's survey is to focus on symptoms, whether or not you have ever or have recently had COVID. You will receive a $20 Amazon gift card for completing the survey.

## Sociodemographics

1. Are you currently…? (Source: BRFSS, 2019; C3, V0-V10 )
    a. Employed for wages
    b. Self-employed
    c. Out of work for less than 1 year
    d. Out of work for 1 year or more
    e. A homemaker
    f. A student
    g. Retired

2. *If out of work*: Are you receiving unemployment benefits, or have you filed for unemployment benefits? (Source: C3, V0-V10)
    a. Yes, I am receiving unemployment
    b. Yes, I have filed for and am waiting to hear about eligibility
    c. Yes, I have filed for and am waiting to receive unemployment
    d. No, I am not receiving, filing or eligible for unemployment.
    e. No, my unemployment benefits expired.
    f. Don't know / Not sure

3. **In the past month (since** *ADD Qualtrics DD/Mon/YY***),** have you experienced a significant personal loss of income as a result of COVID-19? (Source: C3, V0-V10)
    a. Yes
    b. No

c. Not applicable

4. *If Yes experienced a personal loss of income:* Which of the following contributed to a personal loss of income? **Please select all that apply.** (Source: C3, V0-V10)
   a. I was fired / laid off
   b. I was given time off without pay (not fired, but not working)
   c. I was given time off with reduced pay (employer provided benefits)
   d. My hours were reduced
   e. I could not work and care for or educate a child in my household
   f. I felt I was at high risk and did not want to leave my home
   g. My business temporarily closed
   h. My business permanently closed
   i. I was sick
   j. I was in quarantine or isolation
   k. I was in the hospital
   l. Other: _____

## Healthcare Access, Insurance Status

5. During the **past 12 months**, have you had either a flu vaccine that was sprayed in your nose or a flu shot injected into your arm? (Source: BRFSS, 2019, negative exposure; C3)
   a. Yes
   b. No
   c. Don't know / Not sure

6. During the **past 12 months**, has anyone else in your household received a flu vaccine that was sprayed in the nose or a flu shot injected into the arm? (Modified from source: BRFSS, 2019, negative exposure)
   a. Yes
   b. No
   c. Don't know / Not sure
   d. Not applicable, I do not live with anyone else

7. Besides yourself, is anyone else in your household fully or partially vaccinated against COVID-19 with a vaccine that has received FDA emergency use authorization or approval (not in a vaccine trial). Please do not include yourself. (Source: C3, V11, negative exposure)
   a. Yes, everyone eligible for vaccination is vaccinated
   b. Yes, some of the people eligible for vaccination are vaccinated
   c. None of the eligible people are vaccinated
   d. Don't know/not sure
   e. Not applicable, I do not live with anyone else

8. Would you say that in general your health is: (Source: CDC's Healthy Days Measure; C3: V2-V10)
   a. Excellent

b. Very Good
c. Fair
d. Poor

## Pre-Existing Conditions and Symptoms

9. Has a doctor, nurse, or other health professional ever told you that you had any of the following? **Please select all that apply** (Source: adapted from BRFSS 2019 to include additional risk factors; C3: v2, v9)
    a. had a heart attack also called a myocardial infarction?
    b. had angina or coronary heart disease?
    c. had type 2 diabetes?
    d. have high blood pressure?
    e. have dyslipidemia (abnormally elevated cholesterol or fats (lipids) in the blood)?
    f. had cancer?
    g. had asthma?
    h. have chronic obstructive pulmonary disease, C.O.P.D., emphysema or chronic bronchitis?
    i. have kidney disease (not including kidney stones, bladder infection or incontinence)?
    j. have chronic liver disease, including cirrhosis?
    k. have HIV/AIDS?
    l. have immunosuppression?
    m. have an autoimmune condition?
    n. had depression?
    o. had post-traumatic stress disorder or PTSD?
    p. had an anxiety disorder?
    q. had chronic fatigue syndrome?
    r. had mononucleosis?
    s. had a traumatic brain injury?
    t. had migraines?
    u. had insomnia or another sleep condition?
    v. had dysautonomia (disorder of the autonomic nervous system (ANS) function)?
    w. been diagnosed with any other condition that you haven't told us about?
    _____
    x. I have not been told that I have any of the above conditions (*exclusive*)

10. *If yes to asthma*: Do you still have asthma? (Source: BRFSS, 2019)
    a. Yes
    b. No
    c. Don't know / Not sure

11. *If yes to any health condition, excluding cancer:* How old were you (in years) when a doctor, nurse, or health professional told you that you had the following…

a. [*prepopulate list of responses endorsed above excluding cancer*] ___ years old

12. *If yes to cancer*:
You've told us that you have had cancer. We would like to ask you a few more questions about your cancer.

What type(s) of cancer? **Please select all that apply.** (Source: adapted from BRFSS 2019)

a. Bladder
b. Blood
c. Bone
d. Brain
e. Breast
f. Cervix / cervical
g. Colon
h. Esophagus / esophageal
i. Gallbladder
j. Kidney
k. Larynx/windpipe
l. Leukemia
m. Liver
n. Lung
o. Lymphoma/Hodgkins' disease
p. Melanoma
q. Mouth/tongue/lip
r. Nervous system
s. Ovary (ovarian)
t. Pancreas / pancreatic
u. Prostate
v. Rectum / rectal
w. Skin (non-melanoma)
x. Skin (don't know what kind)
y. Soft tissue (muscle or fat)
z. Stomach
aa. Testis / testicular
bb. Thyroid
cc. Uterus (uterine)
dd. Other: _____
ee. Don't know / not sure
ff. I have not been told that I have any of the above conditions

13. *If yes to cancer*: How old were you (in years) when you were diagnosed? (Source: adapted from BRFSS 2019)
[*for more than one answer, prepopulate the types of cancer*]

14. Are you currently experiencing any of the following symptoms? **Please select all that apply.** (Source: C3, V4-V10, new items added V11)
    a. Shortness of breath
    b. Difficulty walking more than 15 minutes
    c. Difficulty running / exercising
    d. Fatigue
    e. Fatigue after an activity (e.g., doing dishes, which is sometimes called post exertional malaise)
    f. Headache
    g. Trouble concentrating / brain fog
    h. Dizziness
    i. Irritability
    j. Erratic heartbeat
    k. Gastro-intestinal issues
    l. Low-grade fever
    m. Muscle aches (myalgia)
    n. Loss or altered taste
    o. Loss or altered sense of smell
    p. Waxing and waning of some or all of my initial COVID-19 infection symptoms
    q. Difficulty sleeping
    r. Something else:_____
    s. I am NOT experiencing any of the symptoms above *(exclusive)*

## Vaccine

(Source: All vaccine questions come from C3)

We've been asking you periodically if you've had a COVID-19 vaccine, but we want to make sure our information is correct.

15. *If not fully vaccinated or did not receive vaccine in trial or missing information in previous v6-v10:*

Have you been fully or partially vaccinated against COVID-19 with a vaccine that has received FDA approval or emergency use authorization? (C3: V11)
    a. Yes
    b. No
    c. Don't know / Not sure

16. *If yes to fully or partially vaccinated in this survey or missing response in previous (v6-V10)*: How many doses of the primary vaccine series did you receive? Primary vaccine series means either a 2-dose mRNA COVID-19 vaccine series (Moderna or Pfizer) or a single dose of Johnson & Johnson COVID-19 vaccine. If you received booster doses please do not include them here.
    a. 1
    b. 2

17. *If received 1 dose only or 2 doses & haven't previously reported date & respondent didn't give first date dose in V7.1 & v8 & v9 & v10*: When did you receive your first dose of the COVID-19 vaccine?
    Your vaccination card should have the date of your first shot
    a. Enter date: Month Day Year lookup
    b. Don't know / Not sure

18. *If don't know exact date*: What month did you receive your first dose of the COVID-19 vaccine?
    a. Enter date: Month Year dropdown options
    b. Don't know / Not sure

19. *If don't know month*: Do you recall the season in which you received your first dose of the COVID-19 vaccine?
    a. Enter date: Season & Year dropdown options
    b. Don't know / Not sure

20. *If received 2 doses*: When did you receive your second dose of the COVID-19 vaccine?
    Your vaccination card should have the date of your second shot.

    Please note that you entered [*piped text of first dose date*] as the first COVID-19 vaccine date. Please make sure the date of your first dose is before the date of your second dose. If the first dose date is wrong, please go back to change the date.

    a. Enter date: Month Day Year lookup
    b. Don't know / Not sure

21. *If don't know exact date*: What month did you receive your second dose of the COVID-19 vaccine?
    a. Enter date: Month Day Year lookup
    b. Don't know / Not sure

22. *If don't know month*: Do you recall the season in which you received your second dose of the COVID-19 vaccine?
    a. Enter date: Season & Year dropdown options
    b. Don't know / Not sure

23. *If yes to vaccinated in V11 or missing information in previous v6-v10*: Which COVID-19 vaccine did you get?
    a. Pfizer/BioNTech
    b. Moderna
    c. AstraZeneca-Oxford
    d. Johnson & Johnson / Beth Israel Deaconess
    e. Novavax
    f. Other: _____
    g. Don't know / Not sure

24. *Asked of everyone who reported vaccination previously or in V11*: Have you received a COVID-19 booster?
    a. Yes
    b. No [*If no, skip to Q37]*
    c. Don't know / Not sure

25. *If yes to booster:* How many booster doses did you receive?
    a. 1
    b. 2
    c. More than 2

26. *If yes to booster & 1 dose & 2 doses & More than 2:* Which **first booster dose (or only booster dose)** did you receive?
    a. Pfizer/BioNTech
    b. Moderna
    c. AstraZeneca-Oxford
    d. Johnson & Johnson / Beth Israel Deaconess
    e. Novavax
    f. Other: _____
    g. Don't know / Not sure

27. *If received booster & 1 dose & 2 doses & More than 2*: When did you receive your **first booster dose (or only booster dose)** for the COVID-19 vaccine?
    a. Enter date: Month Day Year lookup
    b. Don't know / Not sure

28. *If don't know exact date*: What month did you receive your **first booster dose (or only booster dose)** for the COVID-19 vaccine?
    a. Enter date: Month Year dropdown options
    b. Don't know / Not sure

29. *If yes to booster & 2 dose & More than 2 doses:* Which **second booster dose** did you receive?
    a. Pfizer/BioNTech

b. Moderna
c. AstraZeneca-Oxford
d. Johnson & Johnson / Beth Israel Deaconess
e. Novavax
f. Other: _____
g. Don't know / Not sure

30. *If received booster & 2 dose & More than 2 doses*: When did you receive your **second booster dose** for the COVID-19 vaccine?

    Please note that you entered [*piped text of first dose booster date*] as the first booster date. Please make sure the date of your first dose is before the date of your second dose. If the first dose date is wrong, please go back to change the date.

    a. Enter date: Month Day Year lookup
    b. Don't know / Not sure

31. *If don't know exact date*: What month did you receive your **second booster dose** for the COVID-19 vaccine?
    a. Enter date: Month Year dropdown options
    b. Don't know / Not sure

32. *If yes to booster & More than 2 doses:* Which **third booster dose** did you receive?
    a. Pfizer/BioNTech
    b. Moderna
    c. AstraZeneca-Oxford
    d. Johnson & Johnson / Beth Israel Deaconess
    e. Novavax
    f. Other: _____
    g. Don't know / Not sure

33. *If received booster & More than 2 doses:* When did you receive your **third booster dose** for the COVID-19 vaccine?

    Please note that you entered [*piped text of second dose booster date*] as the second booster date. Please make sure the date of your second dose is before the date of your third dose. If the second dose date is wrong, please go back to change the date.

    a. Enter date: Month Day Year lookup
    b. Don't know / Not sure

34. *If don't know exact date*: What month did you receive your **third booster dose** for the COVID-19 vaccine?

a. Enter date: Month Year dropdown options
b. Don't know / Not sure

35. *If no/don't know to getting the booster (or have had any? boosters) in v11:* Now that boosters are available, will you:
    a. Immediately get a booster
    b. Delay getting a booster
    c. Never get the booster

36. *if no to booster.* Which of the following influenced your decision to not get a booster? **Please select all that apply**.
    a. I don't believe I need an additional booster dose
    b. There is not enough evidence that the booster dose is effective
    c. I'm not yet eligible for the booster dose
    d. I'm not sure if i'm eligible for the booster dose
    e. Short-term side effects
    f. Long-term side effects
    g. Whether other people I know also get it
    h. I think that other people should get it before me
    i. I need more information about the booster dose
    j. I already had COVID
    k. I don't think I am at risk for getting COVID
    l. I have a medical condition which prevents me from getting boosted
    m. Issues accessing a booster dose at a time (or venue) that works for me
    n. Issues accessing a specific vaccine booster dose versus the one that is available
    o. Lack of FDA full approval (Johnson & Johnson vaccine)
    p. Other _____
    q. None of the above

37. *If yes to booster*: What motivated you to get the booster dose(s)? **Please select all that apply**.
    a. I believe the vaccine effectiveness due to my primary vaccine could be waning
    b. I'm concerned about new coronavirus variants such as Delta and Omicron
    c. It is required for travel outside the US
    d. It is required by my employer
    e. It is required by my school/university
    f. I want to visit my family
    g. I want to help reduce the burden on the healthcare system
    h. I want to help end the pandemic as soon as possible
    i. I believe it is effective
    j. It will help protect me
    k. It will help protect others around me
    l. I trust the FDA emergency use authorization and approval process
    m. Other _____

38. *If no/don't know to getting the vaccine in V11*: Now that the vaccine is available to everyone **over 5**, will you:
    a. Immediately get the vaccine
    b. Delay getting the vaccine
    c. Never get the vaccine

39. *If delay or never get vaccine*: Which of the following influenced your decision NOT to get a vaccine? **Please select all that apply**.
    a. Short-term side effects
    b. Long-term side effects
    c. Vaccine effectiveness
    d. Whether other people I know also get it
    e. I think that other people should get it before me
    f. I need more information about the vaccine
    g. I already had COVID
    h. I don't think I am at risk for getting COVID
    i. I have a medical condition which prevents me from getting vaccinated
    j. Issues accessing a vaccine at a time that works for me
    k. Issues accessing a specific vaccine versus the one that is available
    l. Lack of FDA approval (Johnson & Johnson vaccine)
    m. Other _____
    n. None of the above

40. *If immediately get the vaccine*: What motivates you to get the vaccine? **Please select all that apply**.
    a. I'm concerned about new coronavirus variants such as Delta and Omicron
    b. It is required for travel outside the US
    c. It is required by my employer
    d. It is required by the school where I am a student
    e. I want to avoid getting COVID-19
    f. I want to visit my family
    g. I want to help reduce the burden on the healthcare system
    h. I want to help end the pandemic as soon as possible
    i. I believe it is effective
    j. It will help protect me
    k. It will help protect others around me
    l. I trust the FDA emergency use authorization and approval process
    m. Final FDA approval for Pfizer and Moderna vaccines in adults
    n. Other _____

## Testing and Diagnosis

41. We've been asking you periodically if you've ever had COVID, but we want to make sure our information is correct.
    Have you **ever** had COVID or a positive/reactive test?
    (Source C3, V8)
    a. Yes
    b. No. *If no, skip to end of section*
    c. Don't know / Not sure

42. Since you completed your last survey (on ADD Qualtrics DD/Mon/YY), were any of your viral (PCR or rapid or at-home rapid) test(s) positive/reactive? (Source C3, V4-V10)

    A viral test can show if you are currently infected. Viral tests (PCR or rapid tests or at-home rapid tests) identify virus in samples from your respiratory system, such as swabs from the inside of your nose.
    a. Yes
    b. No
    c. I am still waiting for test results
    d. Don't know / Not sure

43. *If ever had COVID or COVID in v11*, How many times have you had COVID-19 once or more than once? (Source C3, V8)
    a. Once
    b. Twice
    c. Three times
    d. Four times or more

44. *If had COVID twice or three times or four times or more*: When was **the first time (or the only time)** you had COVID? (Source C3, V8)
    If once: When did you have COVID? (Source C3, V8)
    a. Enter date: Month Year dropdown options

45. *If had COVID twice or three times or four times or more*: How did you know you had COVID **the first time (or the only time)**? **Please select all that apply.** (Source C3, V8, edited V11)
    If once: How did you know you had COVID? Please select all that apply.
    Antibody test, also called a serology test, is a blood test that can show if you had a past infection with the coronavirus.
    Close contact with someone who has COVID-19 is defined as being within approximately 6 feet for more than 10 minutes with or without a mask, indoors or outdoors.

COVID-19 symptoms include: fever of 100 degrees or greater, cough, runny nose and/or nasal congestion, shortness of breath, sore throat, fatigue, muscle/body aches, headache, loss of taste/smell, nausea, vomiting, diarrhea

a. COVID-19 diagnosis or a positive/reactive rapid test or PCR
b. Antibody test from our study
c. Another antibody test
d. COVID-19 symptoms
e. Close contact with someone who had COVID-19
f. Other (text entry)
g. Don't know/ not sure

46. *If had COVID twice or three times or four times or more:* When was the second time you had COVID? (Source C3, V8)

    Please note that you entered [*piped text of first infection date*] as your first infection date. Please make sure the date of your first infection is before the date of your second infection. If the date of your first infection is wrong, please go back to change the date.

    a. Enter date: Month Year dropdown options

47. *If had COVID twice or three times or four times or more:* How did you know you had COVID the second time? Please select all that apply. (Source C3, V8)
    a. COVID-19 diagnosis or a positive/reactive rapid test or PCR
    b. Antibody test from our study
    c. Another antibody test
    d. COVID-19 symptoms
    e. Close contact with someone who had COVID-19
    f. Other (text entry)
    g. Don't know/ not sure

48. *If had COVID three times or four times or more: When* was the third time you had COVID? (Source C3, V8)

    Please note that you entered [*piped text of second infection date*] as your second infection date. Please make sure the date of your second infection is before the date of your third infection. If the date of your second infection is wrong, please go back to change the date.

    a. Enter date: Month Year dropdown options

49. *If had COVID three times or four times or more*: How did you know you had COVID the third time? Please select all that apply. (Source C3, V8)
    a. COVID-19 diagnosis or a positive/reactive rapid test or PCR
    b. Antibody test from our study

c. Another antibody test
d. COVID-19 symptoms
e. Close contact with someone who had COVID-19
f. Other (text entry)
g. Don't know/ not sure

50. *If had COVID four times or more:* When was **the fourth time** you had COVID? (Source C3, V8)

    Please note that you entered [*piped text of third infection date*] as your third infection date. Please make sure the date of your third infection is before the date of your fourth infection. If the date of your third infection is wrong, please go back to change the date.

    a. Enter date: Month Year dropdown options

51. *If had COVID four times or more:* How did you know you had COVID **the fourth time**? **Please select all that apply.** (Source C3, V8)
    a. COVID-19 diagnosis or a positive/reactive rapid test or PCR
    b. Antibody test from our study
    c. Another antibody test
    d. COVID-19 symptoms
    e. Close contact with someone who had COVID-19
    f. Other (text entry)
    g. Don't know/ not sure

52. *If ever COVID in v11 or COVID in v11:* Would you describe yourself as having "long COVID", that is, you are still experiencing symptoms more than 4 weeks after you first had COVID-19, that are not explained by something else? (Source: ONS, V11)
    a. Yes
    b. No
    c. Don't know/ Not sure

53. Now we would like to ask you about things you might have tried to improve your symptoms the time(s) you had COVID.

    *If identify as ever HAD COVID or COVID in V11:* Have you tried any of the following for COVID symptoms?
    Please select all that apply. (Source: C3, V10)
    a. Symptoms eventually went away with time
    b. Medication to reduce symptoms
    c. Diet modifications
    d. Physical therapy
    e. Respiratory therapy (e.g. breathing exercises)

f. Respiratory assistance (e.g. inhaler, oxygen)
g. Occupational therapy
h. Monoclonal antibodies
i. Paxlovid
j. Molnupiravir
k. COVID-19 vaccination
l. Vitamins or herbal supplements
m. Other (text)
n. I didn't have symptoms (exclusive)
o. None of the above (exclusive)

54. *If yes to any resource:* did you find [*prepopulate list of responses endorsed above*] helpful for reducing COVID symptoms?
    a. Yes
    b. No
    c. Don't know / Not sure

## Symptoms

55. Since you completed your **last survey (on** *ADD Qualtrics DD/Mon/YY***)**, have you had any of the following symptoms? **Please select all that apply**.

    **Please do not include side effects that you experienced after receiving a COVID-19 vaccination or booster** (usually occurring 24-48 hours after receiving a vaccination or booster). (Source, C3 V0-V10)
    a. Headache
    b. Cough (new since you completed your last survey)
    c. Coughing up phlegm
    d. Coughing up blood
    e. Sore throat
    f. Fever
    g. Muscle aches (myalgia)
    h. Chills
    i. Repeated shaking and chills
    j. Runny nose
    k. Nasal congestion
    l. Sneezing
    m. Chest pain
    n. Shortness of breath
    o. Itchy eyes
    p. Eye pain
    q. Loss or altered sense of smell of smell (new since you completed your last survey)
    r. Loss or altered sense of taste (new since you completed your last survey)

s. Rash
t. Stomach ache
u. Nausea
v. Diarrhea
w. Vomiting
x. I have not had any of these symptoms

56. *If selected any symptom:* Have you seen or called a physician or health care professional for any of these symptoms?
    a) Yes
    b) No
    c) Don't know / Not sure

57. *If selected any symptom:* Since you completed your last survey (on ADD Qualtrics DD/Mon/YY), were you hospitalized for any of these symptoms? (Source C3, V0-V10)
    a) Yes
    b) No
    c) Don't know / Not sure

58. *If the most recent infection was within 9 months (infection date reported in Q43, 45, 47, 49):* Did you have [populate the following symptoms] before or after your most recent COVID infection?

    Please check all time periods that you experienced that symptom. (Source: NICE & NICE survey)
    a. Before your most recent COVID infection
    b. 1 month after your most recent COVID infection
    c. 3 months after your most recent COVID infection
    d. 6 months after your most recent COVID infection
    e. I didn't experience it at any of those times (exclusive)

The list of symptoms:
Fever; Fatigue; Pain;
Cough; Breathlessness;
Chest tightness; Chest Pain; Palpitations;
Brain fog, memory/concentration loss; Headache; Sleep disturbance; Delirium; Dizziness;
Loss or change to your sense of taste/smell; Pins and needles/numbness;
Joint pain; Muscle pain;
Symptoms of depression; Symptoms of anxiety;
Abdominal pain; Nausea; Diarrhea; Anorexia/loss of appetite; Digestive disorders;
Tinnitus; Earache; Sore throat;
Skin rash

59. *If skipped V4/V5/V6/V7/V8/V9/V10 or don't know/no in response to long-haul questions in V4/V5/V6/V7/V8/V9/V10*: Some people report having persistent coronavirus symptoms, weeks

and months after they first became sick. These people are sometimes known as COVID "long-haulers" or having "long-haul symptoms" or "long COVID". Some evidence suggests this can happen to people even if they did not have a positive antibody test. Do you think of yourself as a COVID "long-hauler"? (Source: C3, V4-V10)

a. Yes
b. No
c. Don't know / Not sure

60. *If people haven't previously identified they have long-haul by a doctor in v10:*
Have you been told by a **doctor** that you might have long COVID? (Source: C3, V10)

"Long COVID" means having persistent coronavirus symptoms, weeks and months after someone first became sick.

a. Yes
b. No *[If No, skip to next section]*
c. Don't know/not sure

61. *If yes to self-identified long-hauler (C3 or ONS) or told by a doctor, display in v11:* The following question is about your experience with long-haul symptoms or long COVID.

When did your initial symptoms start? (Source: C3, V4-V10)

a. December 2019
b. January 2020
c. February 2020
d. March 2020
e. April, 2020
f. May 2020
g. June 2020
h. July 2020
i. August 2020
j. September 2020
k. October 2020
l. November 2020
m. December 2020
n. January 2021
o. February 2021
p. March 2021
q. April 2021
r. May 2021
s. June 2021
t. July 2021
u. August 2021
v. September 2021

w. October 2021
x. November 2021
y. December 2021
z. January 2022
aa. February 2022
bb. March 2022
cc. April 2022
dd. May 2022
ee. June 2022
ff. July 2022

## Recovery *[only asked of those reported ever covid in v11 OR long-hauler]*

62. *If had COVID in or after November 2021:* When you had COVID or a positive/reactive test, were you prescribed antiviral medications (paxlovid or molnupiravir), which are taken as pills for 5 days, immediately after you were diagnosed? **Please select all that apply.** (Source: C3, V11)
    a. Paxlovid
    b. Molnupiravir
    c. Other: _____
    d. I was not prescribed an antiviral medication

63. *If yes:* Did you take these antiviral medications as prescribed? (Source: C3, V11)
    a. Yes
    b. Some, but not all
    c. No
    d. Don't know / Not sure

64. *If ever had COVID or COVID in v11:* When you had COVID or a positive/reactive test, did you receive monoclonal antibodies, which are given intravenously in a health care setting? (Source: C3, V11)
    a. Yes
    b. No
    c. Don't know / Not sure

## Long-haul specific section

*Adding skipping pattern: If self-identified as long COVID (self [C3 or ONS] or doctor) in v11 or previously:* The following section asks about your experience with long COVID or having persistent coronavirus symptoms weeks or months after becoming sick. The details of your experience with long COVID are important to us. This section may take a little more time to complete.

65. *If self-identified as long COVID (self [C3 or ONS] or doctor) in v11 or previously:*
    How would you describe your **long COVID** when it was the absolute worst? (Source: C3, V11)
    a. No to little impact on activities of daily living

b. Little to moderate impact on activities of daily living
c. Moderate impact on activities of daily living
d. Moderate to severe impact on activities of daily living
e. Severe impact on activities of daily living

66. You answered that during the worst period of time your long COVID had [*insert response*], what was the **total duration of that worst period of time**?

**Please answer even if ongoing, and tell us how long you have been feeling this way. (Source: C3, V11)**

a. Less than a week
b. Between a week and a month
c. 1 month to 6 months
d. 6 months to a year
e. More than a year

67. *If ever had COVID or COVID in v11:* Since you had COVID, have you been diagnosed with any medical conditions?

a. Postural orthostatic tachycardia syndrome (POTS)
b. Hypertension / high blood pressure
c. Myalgic encephalomyelitis/chronic fatigue syndrome (ME / CFS)
d. Dysautonomia (disorder of the autonomic nervous system (ANS) function)
e. Any heart condition
f. Any lung or pulmonary condition
g. Seizures
h. Guillain-Barre Syndrome
i. Parkinson's disease
j. Alzheimer's disease
k. Blood clots
l. Depression
m. Anxiety
n. Migraines
o. Abnormally elevated cholesterol or fats (lipids) in the blood (Dyslipidemia)
p. Insomnia
q. Traumatic brain injury
r. Other mental health diagnosis _____
s. Anything else _____
t. I have not been diagnosed with any of the above conditions

68. *If ever reported COVID or COVID in v11 or ever self identified as long hauler previously (C3 or ONS) and in v11 or ever told be a doctor as long hauler previously and in v11 :* Compared to when you first got sick with COVID, how do you feel right now? (Source: C3, V4-V10, modified V11)
    a. Worse than I felt initially
    b. About the same
    c. Somewhat better
    d. Much better, but not totally really recovered
    e. Totally recovered
    f. I did not mean to identify as a long hauler *(skip to Quality of life)*
    g. Don't know / Not sure

69. *If selected e "Totally recovered" & identified as a long hauler in v11 or previously.*

    How long did your symptoms last? (Source: C3, V11)
    a. Less than a week
    b. Between a week and a month
    c. 1 month to < 6 months
    d. 6 months to a year
    e. More than a year

70. *If reported at least one vaccine dose and id as having long haul (self (C3 or ONS) or doctor):* Do you think your long haul symptoms have improved since you were vaccinated? (Source: C3, V7-V10)
    a. Yes
    b. No
    c. Don't know / Not sure
    d. Not applicable

71. *If reported at least one booster and id as having long haul (self (C3 or ONS) or doctor):* Do you think your long haul symptoms have improved since you were boosted? (Source: C3, V11)
    a. Yes
    b. No
    c. Don't know / Not sure
    d. Not applicable

72. If reported long-haul (self (C3 or ONS) or doctor) previously or in v11, Have you tried any of the following for long-haul COVID symptoms? **Please select all that apply. Please feel free to list any additional resources that are not included.** (Source: C3, V7-V10, modified V11)
    a. Symptoms eventually went away with time
    b. Medication to reduce symptoms

c. Diet modifications
d. Physical therapy
e. Respiratory therapy (e.g. breathing exercises)
f. Respiratory assistance (e.g. inhaler, oxygen)
g. Occupational therapy
h. Monoclonal antibodies
i. Paxlovid
j. Molnupiravir
k. COVID-19 vaccination
l. Vitamins or herbal supplements
m. Other (text)
n. I didn't have symptoms (exclusive)
o. None of the above (exclusive)

73. If yes to any resource: did you find [*prepopulate list of responses endorsed above*] helpful for reducing long-haul COVID symptoms?
    a. Yes
    b. No
    c. Don't know / Not sure

74. **If reported long-haul (self (C3 or ONS)) previously or in v11,** Have you had difficulty finding a doctor to treat your long-haul COVID symptoms? (Source: C3, V7-V10)
    a. Yes
    b. No
    c. Don't know/not sure

75. *If self identified as long hauler in v11 (C3 or ONS):* Why do you think that you have long-haul COVID? **Please select all that apply.** (Source: C3, V10)
    a. Persistent symptoms
    b. A doctor told me
    c. Other_____
    d. Don't know/not sure

## Stigma

(Source: Stigma Scale for Chronic Illness) *[covid + long haul]*

*If identified as having long COVID (self id (C3 or ONS) or doctor diagnosed):*
The following questions ask about your personal experience with **long COVID**.

*If identified as NOT having long COVID (self id or doctor diagnosed) but have ever had COVID or COVID in v11:* The following questions ask about your personal experience with **COVID**.

76. Because of my illness, some people seemed uncomfortable with me
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

77. Because of my illness, some people avoided me
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

78. Because of my illness, I felt left out of things
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

79. Because of my illness, people were unkind to me
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

80. Because of my illness, people avoided looking at me
    a. Never

b. Rarely
c. Sometimes
d. Often
e. NA

81. I felt embarrassed about my illness
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

82. I felt embarrassed because of my physical limitations
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

83. Some people acted as though it was my fault I have this illness
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. NA

## Quality of Life

84. Since your **last survey (*on*** ADD *Qualtrics DD/Mon/YY)*, how much difficulty do you have engaging in daily activities (or household responsibilities) because of physical, mental, or emotional problems? (Source: C3, V1-V10, modified from a BRFSS question)
    a. No difficulty
    b. Some difficulty
    c. A lot of difficulty
    d. Don't know / Not sure

Under each heading, please select one response that best describes your health TODAY (Source: Euro Qol 5D, recommended by CDC for long-haul evaluation)

85. Mobility
    a. I have no problems in walking about

b. I have slight problems in walking about
c. I have moderate problems in walking about
d. I have severe problems in walking about
e. I am unable to walk about

86. Self-care
    a. I have no problems washing or dressing myself
    b. I have slight problems washing or dressing myself
    c. I have moderate problems washing or dressing myself
    d. I have severe problems washing or dressing myself
    e. I am unable to wash or dress myself

87. Usual activities (e.g. work, study, housework, family or leisure activities)
    a. I have no problems doing my usual activities
    b. I have slight problems doing my usual activities
    c. I have moderate problems doing my usual activities
    d. I have severe problems doing my usual activities
    e. I am unable to do my usual activities

88. Pain or discomfort
    a. I have no pain or discomfort
    b. I have slight pain or discomfort
    c. I have moderate pain or discomfort
    d. I have severe pain or discomfort
    e. I have extreme pain or discomfort

89. Anxiety or depression
    a. I am not anxious or depressed
    b. I am slightly anxious or depressed
    c. I am moderately anxious or depressed
    d. I am severely anxious or depressed
    e. I am extremely anxious or depressed

90. We would like to know how good or bad your health is TODAY. This scale is numbered from 0 to 100. 100 means the best health you can imagine. 0 means the worst health you can imagine. Select the number to indicate how your health is TODAY. (Source: Euro Qol 5D)
    [*Scale from 0 to 100*]

91. The next set of questions is about fatigue.

    Please select the extent to which you agree with the following statements.

    This refers to your usual way of life within **the last week**. (Source: Fatigue Severity Scale, recommended by CDC for long-haul evaluation)

    Scales: ["Strongly disagree"; "disagree"; "somewhat disagree"; "neither disagree nor agree"; "somewhat agree"; "agree"; "Strongly agree."]

    a. My motivation is lower when I am fatigued
    b. Exercise brings on my fatigue
    c. I am easily fatigued
    d. Fatigue interferes with my physical functioning
    e. Fatigue causes frequent problems for me
    f. My fatigue prevents sustained physical functioning
    g. Fatigue interferes with carrying out certain duties and responsibilities
    h. Fatigue is among my most disabling symptoms
    i. Fatigue interferes with my work, family, or social life

92. The next few questions ask about difficulties in thinking or remembering that can make a big difference in everyday activities. This does not refer to occasionally forgetting your keys or the name of someone you recently met, which is normal. This refers to confusion or memory loss that is happening more often or getting worse, such as forgetting how to do things you've always done or forgetting things that you would normally know. We want to know how these difficulties impact you. (Source: BRFSS)

    During the **past 12 months**, have you experienced confusion or memory loss that is happening more often or is getting worse?

    a. Yes
    b. No if no - skip to next Q108
    c. Don't know / Not sure

93. During the **past 12 months**, as a result of confusion or memory loss, how often have you given up day -to -day household activities or chores you used to do, such as cooking, cleaning, taking medications, driving, or paying bills? Would you say it is…

    a. Always
    b. Usually
    c. Sometimes
    d. Rarely
    e. Never

f. Don't know/Not sure

94. As a result of confusion or memory loss, how often do you need assistance with these day -to - day activities? Would you say it is…
    a. Always
    b. Usually
    c. Sometimes
    d. Rarely
    e. Never
    f. Don't know/Not sure

95. When you need help with these day -to - day activities, how often are you able to get the help that you need? Would you say it is…
    a. Always
    b. Usually
    c. Sometimes
    d. Rarely
    e. Never
    f. Don't know/Not sure

96. During the **past 12 months**, how often has confusion or memory loss interfered with your ability to work, volunteer, or engage in social activities outside the home? Would you say it is…
    a. Always
    b. Usually
    c. Sometimes
    d. Rarely
    e. Never
    f. Don't know/Not sure

97. Have you or anyone else discussed your confusion or memory loss with a healthcare professional?
    a. Yes
    b. No
    c. Don't know / Not sure

98. Now thinking about your physical health, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health **not good**? (Source: CDC's Healthy Days Measure; C3, V2-V10)
    a. _____ *Number of days from 1-30*
    b. None
    c. Don't know / Not sure

99. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the **past 30 days** was your mental health **not good**? (Source: CDC's Healthy Days Measure; C3, V2-V10)
    a. _____ *Number of days from 1-30*
    b. None
    c. Don't know / Not sure

100. During the **past 30 days,** for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation? (Source: CDC's Healthy Days Measure; C3, V2-V10)
    a. _____ *Number of days from 1-30*
    b. None
    c. Don't know / Not sure

101. During the **past month** (since *ADD Qualtrics DD/Mon/YY)*, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise? (Source: BRFSS, 2019; C3, V3-V10)
    a. Yes
    b. No
    c. Don't know / Not sure

102. If yes to any physical activities or exercises, How many times per week or per month did you take part in this activity during the past month? (Source: BRFSS, 2019; C3, V2-V10)
    a. __ Times per week
    b. __ Times per month
    c. Don't know / Not sure

103. If yes to any physical activities or exercises, And when you took part in this activity, for how many minutes or hours did you usually keep at it? (Source: BRFSS, 2019; C3, V2-V10)
    a. __ Number of hours
    b. __ Number of minutes
    c. Don't know / Not sure

## Anxiety & Risk Perception

104. *If ever had COVID in V11 or COVID in v11:* How worried are you about getting sick from COVID-19 **again**? Would you say: (Source: C3, V3-V10)
    a. Not at all worried
    b. Not too worried
    c. Somewhat worried
    d. Very worried

105. *If never indicated COVID diagnosis in V11:* How worried are you about getting sick from COVID-19? Would you say: (Source: C3, V0-V10)
   a. Not at all worried
   b. Not too worried
   c. Somewhat worried
   d. Very worried

106. **In the past month (since** *ADD Qualtrics DD/Mon/YY***)**, how often have you been bothered by the following problems (Source: GAD7, PHQ8)

| Have you been bothered by… | Not at all | Several days | Over 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's hard to sit still | | | | |
| Becoming easily annoyed or irritable | | | | |
| Feeling afraid as if something awful might happen | | | | |
| 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 | | | | |

## END OF SURVEY

Thank you for taking the time to complete this follow-up survey. You will hear from us in September with the next follow-up survey. In the interim, we may periodically reach out to invite you to participate in short surveys with only a few questions or any other studies you may be eligible for. A confirmation email with the details has also been sent to you. If you want to request free at-home COVID-19 test kits, please visit covidtests.gov to place an order. For resources related to mental health, substance use,

violence, and food banks in your area, please visit our website, https://cunyisph.org/cunycovidfacts/.

For up to date and accurate information about the coronavirus, please visit our website, https://cunyisph.org/cunycovidfacts/ or visit CDC.gov.

If you have any questions, reach us here: covid@sph.cuny.edu