



CHASING
COVID
COHORT

June 14, 2023

Long COVID Follow-up Survey

Consent

If missing v14 consent:

Thank you very much for your participation in the CHASING COVID Cohort (C3) study thus far. Our study team has received additional funding and will continue to follow up with participants in the cohort.

The COVID-19 pandemic has evolved significantly during the course of this study. Your ongoing participation has provided valuable information for understanding the impact of COVID-19 across the U.S.. Thanks to your participation, the CHASING COVID Cohort is one of a few longitudinal community-based studies that has documented the full and lasting impact of the pandemic across various aspects of daily life, and it will serve as critically important data for understanding the trajectory of the pandemic.

To date, the CHASING COVID Cohort study has been conducted by the CUNY Institute for Implementation Science in Population Health (ISPH), with support from the National Institutes of Health and Pfizer. The risks and benefits of participating in this study remain the same. Just like before, your identifiable data and specimens will never be shared with anyone outside the CUNY study team. You will be invited to participate in at least 1 more survey in 2023. Incentives for completing a survey and antibody specimen collection will remain the same.

If you have questions, please contact us at covid@sph.cuny.edu.

1) CONSENT STATEMENTS:

I have read and understood the information above. I understand that participation in this study is voluntary and that I may withdraw from the study at any time.

- a) Yes, I consent to continue in this study
- b) No, I do not consent to continue in this study

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If not consented in V15:

You have chosen to not continue participating in the Chasing COVID study. If this was an error, please click the back button to change your response.

If this is correct, please click the next button to end the survey. [Pressing next ends survey]

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.

This survey may look a little different from previous surveys. The aim of today's survey is to focus on symptoms, and whether or not you have ever or recently had COVID.

You will receive a \$20 *Tremendous* gift card for completing the survey. *Tremendous* offers over 700 redeeming options, including Visa virtual gift cards, Amazon, Target, Starbucks, various charities, and more. Now you can choose which type of gift card you receive.

- 2) *If no phone number on file as of V14, skip to next question: We have this number for text message reminders. Is this correct?: <Enter phone number on file from V14>*
 - a) Yes, this is correct
 - b) No
 - c) Don't know / Not sure

- 3) *If no or don't know or no phone number on file: What is a good phone number where we can reach you? (We will never share your information with anyone. Standard messaging rates may apply.)*
 - a) _____ Phone Number
 - b) _____ Please confirm your phone number

Antibody Specimen Collection

- 4) *If yes to antibody specimen collection in V14: You consented to participate in another round of specimen collection in your last survey (on [piped last survey date]). We hope specimen collection kits will begin shipping in a few weeks. Is this still the address you would like your kit sent to?*
[Pipe address as entered in V14]
 - a) Yes, this address is correct
 - b) No, I would like to enter a new address

*If no to antibody specimen collection in V14: Today, we would like to give you another opportunity to participate in one round of specimen collection for COVID-19 antibody testing. Similar to previous antibody testing, once the lab receives your returned kit, you will receive an additional \$30 Tremendous gift card. **We hope to begin shipping specimen collection kits in a few weeks.***

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If skipped v14: Today, we are also inviting you to participate in one round of specimen collection for COVID-19 antibody testing. Similar to previous antibody testing, once the lab receives your returned kit, you will receive an additional \$30 Tremendous gift card. **We hope to begin shipping specimen collection kits in a few weeks.**

- 5) *If no to antibody specimen collection in V14 or skipped v14:* Would you like to submit a specimen for antibody testing?
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 6) *If yes to antibody specimen collection in V15 OR participant responded 'no, would like to enter a new address' to address confirmation in V15:* Thank you for agreeing to provide a specimen for antibody testing. Where should we send your collection kit? (We expect to start shipping the specimen collection kits in mid June)
- a) Enter address

Sociodemographics

- 7) Are you currently...? (Source: [BRFSS, 2019](#); C3, V0-V14)
- 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
- 8) *If out of work:* Are you receiving unemployment benefits, or have you filed for unemployment benefits? (Source: C3, V0-V14)
- 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
- 9) Are you currently living in the United States or in the US Territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands)? This does **not** refer to temporarily being outside the country, e.g., on vacation. Please select yes if located on an overseas military base.
- a) Yes
 - b) No, I am temporarily outside of the US, but still live

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- 10) What is your current ZIP code of residence?
- a) _____ [Validate as zip]
 - b) Not applicable
 - c)

Pre-Existing Conditions and Symptoms

- 11) 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)
- a) A heart attack, also called a myocardial infarction
 - b) Angina or coronary heart disease
 - c) Type 2 diabetes
 - d) High blood pressure
 - e) Dyslipidemia (abnormally elevated cholesterol or fats (lipids) in the blood)
 - f) Cancer
 - g) Asthma
 - h) Chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis
 - i) Kidney disease (not including kidney stones, bladder infection or incontinence)
 - j) Chronic liver disease, including cirrhosis
 - k) HIV/AIDS
 - l) Immunosuppression
 - m) Autoimmune condition
 - n) Depression
 - o) Post-traumatic stress disorder or PTSD
 - p) An anxiety disorder
 - q) Chronic fatigue syndrome
 - r) Mononucleosis
 - s) A traumatic brain injury
 - t) Migraines
 - u) Insomnia or another sleep condition
 - v) Dysautonomia (disorder of the autonomic nervous system (ANS) function)
 - w) 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*)
- 12) *If yes to asthma:* Do you still have asthma? (Source: [BRFSS, 2019](#))
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 13) *If yes to any health condition, excluding cancer:* How old were you 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

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- 14) *If yes to 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
- 15) *If yes to cancer:* How old were you when you were diagnosed? (Source: adapted from [BRFSS 2019](#))
[for more than one answer, prepopulate the types of cancer]
- 16) Are you currently experiencing any of the following symptoms? **Please select all that apply.**
(Source: C3, V4-V14)
- a) Shortness of breath
 - b) Difficulty walking more than 15 minutes
 - c) Difficulty running / exercising
 - d) Fatigue

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- 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 symptoms
- q) Difficulty sleeping
- r) Something else: _____
- s) I am NOT experiencing any of the symptoms above (*exclusive*)

Vaccine

- 17) *If not fully vaccinated (defined as two doses of an mRNA COVID-19 vaccine series or a single dose of the Johnson & Johnson vaccine) in previous rounds:* Have you received at least one dose of a COVID-19 vaccine that has received FDA approval or emergency use authorization? (Source: C3 V5-14, updated V15)
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 18) *If yes or don't know to at least one dose of a COVID-19 vaccine in this survey:* How many doses of the vaccine (including boosters) have you received to date? (Source: C3 V5-14, updated V15)
- a) 1
 - b) 2
 - c) 3
 - d) 4 or more
- 19) *If reported receiving 1 dose or more in this survey:* When did you receive your first dose of the COVID-19 vaccine? (Source: C3 V5-14)
Your vaccination card should have the date of your first shot
- a) Enter date: Month Day Year lookup
 - b) Don't know / Not sure

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- 20) *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 (Source: C3 V5-14)
b) Don't know / Not sure
- 21) *If don't know month:* Do you recall the season in which you received your first dose of the COVID-19 vaccine? (Source: C3 V5-14)
a) Enter date: Season & Year dropdown options
b) Don't know / Not sure
- 22) *If reported receiving 1 dose or more in this survey:* Do you know which COVID-19 vaccine you got for your first dose? (Source: C3 V5-14)
a) Pfizer/BioNTech
b) Moderna
c) Johnson & Johnson / Beth Israel Deaconess
d) Novavax
e) Other: _____
f) Don't know / Not sure
- 23) *If reported receiving at least 2 doses in this survey:* 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 previously entered 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.* (Source: C3 V5-14)
a) Enter date: Month Day Year lookup
b) Don't know / Not sure
- 24) *If don't know exact date:* What month did you receive your second dose of the COVID-19 vaccine? (Source: C3 V5-14)
a) Enter date: Month Day Year lookup
b) Don't know / Not sure
- 25) *If don't know month:* Do you recall the season in which you received your second dose of the COVID-19 vaccine? (Source: C3 V5-14)
a) Enter date: Season & Year dropdown options
b) Don't know / Not sure
- 26) *If reported receiving 2 doses or more in this survey:* Do you know which COVID-19 vaccine you got for your second dose? (Source: C3 V5-14, updated V15)
a) Pfizer/BioNTech
b) Moderna
c) Johnson & Johnson / Beth Israel Deaconess
d) Novavax
e) Other: _____

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- f) Don't know / Not sure
- 27) *If reported receiving at least 3 doses in this survey:* When did you receive your third dose of the COVID-19 vaccine?
*Your vaccination card should have the date of your third shot.
Please note that you entered [piped text of previously entered second shot date] as the second COVID-19 vaccine date. Please make sure the dates of your earlier doses are before the date of your third dose. If the earlier dose dates are wrong, please go back to change the dates.* (Source: C3 V5-14, updated V15)
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 third dose of the COVID-19 vaccine? (Source: C3 V5-14, updated V15)
a) Enter date: Month Day Year lookup
b) Don't know / Not sure
- 29) *If don't know month:* Do you recall the season in which you received your third dose of the COVID-19 vaccine? (Source: C3 V5-14, updated V15)
a) Enter date: Season & Year dropdown options
b) Don't know / Not sure
- 30) *If reported receiving 3 doses or more in this survey:* Do you know which COVID-19 vaccine you got for your third dose? (Source: C3 V5-14, updated V15)
a) Pfizer/BioNTech
b) Moderna
c) Johnson & Johnson / Beth Israel Deaconess
d) Novavax
e) Other: _____
f) Don't know / Not sure
- 31) *If reported receiving 4 doses or more in this survey:* When did you receive your most recent dose of the COVID-19 vaccine?
*Your vaccination card should have the date of your most recent shot.
Please note that you entered [piped text of previously entered third shot date] as the third COVID-19 vaccine date. Please make sure the dates of your earlier doses are before the date of your most recent dose. If the earlier dose dates are wrong, please go back to change the dates.* (Source: C3 V5-14, updated V15)
a) Enter date: Month Day Year lookup
b) Don't know / Not sure
- 32) *If don't know exact date:* What month did you receive your most recent dose of the COVID-19 vaccine? (Source: C3 V5-14, updated V15)
a) Enter date: Month Day Year lookup
b) Don't know / Not sure

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- 33) *If don't know month:* Do you recall the season in which you received your most recent dose of the COVID-19 vaccine? (Source: C3 V5-14, updated V15)
- a) Enter date: Season & Year dropdown options
 - b) Don't know / Not sure
- 34) *If reported receiving four doses or more in V15:* Do you know which COVID-19 vaccine you got for your most recent dose? (Source: C3 V5-14, updated V15)
- a) Pfizer/BioNTech
 - b) Moderna
 - c) Johnson & Johnson / Beth Israel Deaconess
 - d) Novavax
 - e) Other: _____
 - f) Don't know / Not sure
- 35) *If no to received at least one dose in v15:* Which of the following influenced your decision to not get a vaccine? Please select all that apply. (Source: C3 V5-14, updated V15)
- 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 recently had COVID
 - i) I don't think I am at risk for getting COVID
 - j) I have a medical condition which prevents me from getting vaccinated
 - k) Issues accessing a vaccine at a time (or venue) that works for me
 - l) Issues accessing a specific vaccine versus the one that is available
 - m) Lack of FDA approval (Johnson & Johnson vaccine)
 - n) I don't like needles/injections
 - o) Other: _____
 - p) None of the above
- 36) *If yes to received at least one dose in v15:* What motivated you to get the vaccine? Please select all that apply. (Source: C3 V5-14, updated V15)
- a) I'm concerned about new coronavirus variants
 - 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

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- 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)
 - n) Other: _____
- 37) *If fully vaccinated (defined as two doses of an mRNA COVID-19 vaccine series or a single dose of the Johnson & Johnson vaccine) as of v14: Since your last survey [piped text of last survey date], have you received an additional COVID-19 vaccine dose (or booster)? (Source: C3 V5-14, updated V15)*
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 38) *If yes to booster since last survey: Since [piped text of last survey date], which **most recent** COVID-19 vaccine (or booster) doses did you receive? (Source: C3 V5-14, updated V15)*
- a) Pfizer/BioNTech
 - b) Moderna
 - c) Other: _____
 - d) Don't know / Not sure
- 39) *If received booster since last survey: When did you receive your **most recent** vaccinatedose (or booster)? (Source: C3 V5-14)*
- a) Enter date: Month Day Year lookup
 - b) Don't know / Not sure
- 40) *If don't know exact date: What month did you receive your **most recent** vaccine dose (or booster)? (Source: C3 V5-14)*
- a) Enter date: Month Year dropdown options
 - b) Don't know / Not sure
- 41) *If no to booster in v15: Since your last survey (pipe in last survey date), which of the following influenced your decision to not get an additional COVID-19 vaccine (or booster)? Please select all that apply. (Source: C3 V5-14, updated V14)*
- a) I recently got a booster
 - b) I am up-to-date on boosters
 - c) I don't believe I need an additional booster dose
 - d) There is not enough evidence that the booster dose is effective
 - e) I'm not yet eligible for the booster dose
 - f)
 - g) I'm worried about short-term side effects
 - h) I'm worried about long-term side effects
 - i) Whether other people I know also get it
 - j) I think that other people should get it before me
 - k) I need more information about the booster dose

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- l) I already had COVID
 - m) I recently had COVID
 - n) I don't think I am at risk for getting COVID
 - o) I have a medical condition which prevents me from getting boosted
 - p) Issues accessing a booster dose at a time (or venue) that works for me
 - q) Issues accessing a specific vaccine booster dose versus the one that is available
 - r) Lack of FDA full approval (Johnson & Johnson vaccine)
 - s) I plan to get a booster, but haven't had time yet
 - t) I'm worried that there will be fees or other costs if I get the booster
 - u) I don't like needles/injections
 - v) Other: _____
 - w) None of the above
- 42) *If yes to booster in V15: Since your last survey (pipe in last survey date), what motivated you to get an additional COVID-19 vaccine (or booster) dose ? **Please select all that apply.***
(Source: C3 V5-14, updated V14)
- a) I believe the vaccine effectiveness due to my primary vaccine could be waning
 - b) I'm concerned about new coronavirus variants
 - 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: _____
- 43) How willing are you to receive a future updated vaccine for COVID-19? (Source: v15)
- a) Very willing
 - b) Somewhat willing
 - c) Not willing
 - d) Don't know / Not sure
- 44) *If very willing or somewhat willing to receive a future updated vaccine: How often would you be willing to receive a future updated vaccine for COVID-19? Please select all that apply.*
- a) Once every six months
 - b) Once every year
 - c) As recommended by my physician
 - d) As recommended by the FDA or CDC
 - e) Don't know / not sure

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- 45) What would you consider when making your decision to receive a future updated vaccine for COVID-19? Please select all that apply.
- a) Risk of short-term illness due to COVID
 - b) Risk of long-term illness due to COVID
 - c) Risk of short-term effects of the vaccine
 - d) Risk of long-term effects of the vaccine
 - e) Convenience of getting the vaccine
 - f) Risk of getting others sick
 - g) My age
 - h) Comorbidities I have
 - i) Doctor recommendations about getting the vaccine
 - j) CDC recommendations about getting the vaccine
 - k) Whether I could get other health issues addressed at the same time, e.g., flu shot
 - l) How bad previous infections were for myself or others I know
 - m) I or others I know had reactions to past COVID-19 vaccines
 - n) Cost / insurance
 - o) How well the updated vaccine matches the variants that are causing COVID-19 at the time of my vaccine
 - p) Vaccination method (e.g., nasal spray vs. injection)
 - q) Other: _____
- 46) *If no/don't know to getting an additional shot since last survey:* Now that boosters are available, will you: (Source: C3 V5-14)
- a. Immediately get the booster
 - b. Delay getting the booster
 - c. Never get the booster
 - d. Not applicable - I am up to date

Testing and Diagnosis

- 47) 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?

- a) Yes
 - b) No
 - c) Don't know / Not sure
- 48) Have you had COVID or a positive/reactive test **in the last 9 months (since [piped date])**?
- a) Yes
 - b) No
 - c) Don't know / Not sure

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- 49) Since you completed your **last survey (on ADD Qualtrics DD/Mon/YY)**, have you taken a viral test for COVID-19? A viral test can show if you are currently infected. Viral tests (PCR or rapid tests) identify virus in samples from your respiratory system, such as swabs from the inside of your nose or a saliva sample.
- a) Yes
 - b) No, but I tried and was unable to get a viral test for COVID-19
 - c) No, because I did not need or try to get a viral test for COVID-19
 - d) Don't know / Not sure
- 50) *If yes to viral test:* Since you completed your **last survey (on ADD Qualtrics DD/Mon/YY)**, were any of your viral tests an **at-home rapid** test?
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 51) *If yes to viral test:* Since you completed your **last survey (on ADD Qualtrics DD/Mon/YY)**, were any of your viral (PCR or rapid) test(s) positive/reactive?
- a) Yes
 - b) No
 - c) I am still waiting for test results
 - d) Don't know / Not sure
- 52) *If yes to positive/reactive viral test:* Since your **last survey** (on last survey date), when was your positive viral (PCR or rapid) test? If you had more than one positive test since your last survey, please enter the date of your first positive test.
An approximate date is okay.
- a) __[Date]
 - b) Don't know / Not sure
- 53) *If don't know/not sure about positive/reactive viral test date:* Since your last survey (on [piped last survey date]), what month was your first positive viral (PCR or rapid) test?
- a) Jan 2022
 - b) ...
 - c) June 2023
 - d) Other: _____
 - e) Don't know / Not sure
- 54) *If selected yes was tested or tried to get a test:* What motivated you to get or try to get a test for COVID-19? **Please select all that apply.**
- a) I was experiencing COVID-like symptoms
 - b) I was in contact with someone who had or was suspected to have had COVID-19
 - c) I needed to get a test for **work** (e.g., working in a healthcare or congregate living facility)
 - d) I needed to get a test for **school**
 - e) I belong to a priority population (e.g., having an underlying health condition)

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- f) I attended a gathering with more than 10 people (e.g., a meeting or event)
 - g) Prior to a healthcare visit or procedure
 - h) Prior to seeing friends or family
 - i) After seeing friends or family
 - j) Prior to traveling
 - k) After traveling
 - l) I was just curious
 - m) Other: _____
- 55) How often do you generally test for COVID-19? (Source: V15)
- a) Once a week or more
 - b) Once a month or more, but less than once a week
 - c) As needed, when I think I've been exposed or have symptoms that I think might be associated with COVID-19
 - d) I do not generally test for COVID-19
- 56) Do you consider yourself to be at high risk for severe COVID-19, which may include hospitalization? (Source: V14)
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 57) Since you completed your last survey (on [piped last survey date]), do you personally know anyone who has died of COVID-19? By personally, we mean partners, relatives, friends, or coworkers.
- a) Yes
 - b) No
 - c) Don't know / Not sure

Symptoms

- 58) 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 vaccine dose (usually occurring 24 - 48 hours after receiving a vaccine dose). (Source, C3 V0-V14)

- 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

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- 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
- 59) *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
- 60) *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-V12)
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 61) *If reported COVID in last 9 months or if reported a positive/reactive viral test in v15:*
Thinking about your most recent COVID infection, please check all time periods when you experienced fever. (Source: NICE, V11, V13)
- 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*)
- 62) *Repeat symptoms timing question for:*
- a) Fatigue
 - b) Pain
 - c) Cough
 - d) Breathlessness
 - e) Chest tightness
 - f) Chest pain

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- g) Palpitations
- h) Brain fog, memory/concentration loss
- i) Headache
- j) Sleep disturbance
- k) Delirium
- l) Dizziness
- m) Loss or change to your sense of taste/smell
- n) Pins and needles/numbness
- o) Joint pain
- p) Muscle pain
- q) Symptoms of depression
- r) Symptoms of anxiety
- s) Abdominal pain
- t) Nausea
- u) Diarrhea
- v) Anorexia/Loss of appetite
- w) Digestive disorder
- x) Tinnitus
- y) Earache
- z) Sore throat
- aa) Skin rash

Recovery

[only asked of those reported a positive viral test or ever covid in V15]

You are seeing the following questions because you previously reported having had COVID-19. The questions ask about your experience recovering from COVID-19.

- 63) *If positive/reactive viral test in v15:* Have you tried any of the following for COVID symptoms? **Please select all that apply.** (Source: C3, V10-12)
- a) Medication to reduce symptoms
 - b) Diet modifications
 - c) Physical therapy
 - d) Respiratory therapy (e.g. breathing exercises)
 - e) Respiratory assistance (e.g. inhaler, oxygen)
 - f) Occupational therapy
 - g) Monoclonal antibodies
 - h) Paxlovid (nirmatrelvir; ritonavir), a COVID-19 antiviral
 - i) Lagevrio (molnupiravir), a COVID-19 antiviral
 - j) COVID-19 vaccination
 - k) Vitamins or herbal supplements
 - l) Other: _____

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- m)
 - n) I didn't have symptoms (exclusive)
 - o) None of the above (exclusive)
- 64) For each selected item above: Did you find [tried treatments, excluding o, p] helpful for reducing COVID symptoms?
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 65) *If ever COVID in V15 (positive reactive viral test or yes to ever COVID in V15):* Since you completed your last survey (on ADD Qualtrics DD/Mon/YY), were you prescribed COVID-19 antiviral medications such as Paxlovid (nirmatrelvir; ritonavir) or Lagevrio (molnupiravir) to help with COVID symptoms?
These are generally taken as pills for 5 days. Please select all that apply. (Source: C3, V11-14)
- a) Paxlovid (nirmatrelvir; ritonavir)
 - b) Lagevrio (molnupiravir)
 - c) Other: _____
 - d) I was not prescribed an antiviral medication
- 66) *If prescribed antiviral=Paxlovid:* When were you prescribed Paxlovid? Please select all that apply.
- a) Within 5 days of a positive/reactive test
 - b) Within 6-10 days of a positive/reactive test
 - c) Within 11-30 days of a positive/reactive test
 - d) Within 31-90 days of a positive/reactive test
 - e) 91 or more days after a positive/reactive test
 - f) Don't know / Not sure
- 67) *If prescribed antiviral=Paxlovid:* For the time(s) when you took Paxlovid, was Paxlovid prescribed for more than 5 days? [matrix with answers to When were you prescribed Paxlovid? as rows]?
- a) Yes
 - b) No
 - c) Don't know/Not sure
- 68) *If prescribed antiviral=Paxlovid [with selected answers from When were you prescribed Paxlovid]:* For the time(s) when you took Paxlovid, did you take all the **Paxlovid** pills in your prescription?
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 69) *If prescribed antiviral=Paxlovid:* Did you find Paxlovid helpful for reducing COVID symptoms?
- a) Yes

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- b) No
c) Don't know / Not sure
- 70) *If prescribed antiviral=Molnupiravir with 5-day prescription within 5 days of a positive test:* When were you prescribed Lagevrio (molnupiravir)? Please select all that apply.
a) Within 5 days of a positive/reactive test
b) Within 6-10 days of a positive/reactive test
c) Within 11-30 days of a positive/reactive test
d) Within 31-90 days of a positive/reactive test
e) 91 or more days after a positive/reactive test
f) Don't know / Not sure
- 71) *If prescribed antiviral=Molnupiravir:* For the time(s) when you took Lagevrio (molnupiravir), was Lagevrio (molnupiravir) prescribed for more than 5 days? [with selected answers from When were you prescribed Lagevrio (molnupiravir)]
a) Yes
b) No
c) Don't know / Not sure
- 72) *If prescribed antiviral=Molnupiravir [with selected answers from When were you prescribed Molnupiravir]:* For the time(s) when you took Lagevrio (molnupiravir), did you take all the Lagevrio (molnupiravir) pills in your prescription?
a) Yes
b) No
c) Don't know / Not sure
- 73) *If prescribed antiviral=Molnupiravir:* Did you find Lagevrio (molnupiravir) helpful for reducing COVID symptoms?
a) Yes
b) No
c) Don't know / Not sure
- 74) *If prescribed antiviral=Other:* When were you prescribed [piped in free text in the prescribed antiviral question]? Please select all that apply.
a) Within 5 days of a positive/reactive test
b) Within 6-10 days of a positive/reactive test
c) Within 11-30 days of a positive/reactive test
d) Within 31-90 days of a positive/reactive test
e) 91 or more days after a positive/reactive test
f) Don't know / Not sure
- 75) *If prescribed antiviral=Other:* Did you find [pre-populate text response of 'other' in prescribed antivirals question] helpful for reducing COVID symptoms?
a) Yes

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- b) No
c) Don't know / Not sure
- 76) *[If selected Paxlovid or Molnupiravir]* What type of healthcare setting were you in the last time you received a prescription for an antiviral? (Source: V14)
- a) Doctor's office
 - b) Retail pharmacy
 - c) Telehealth (video) visit
 - d) Urgent care
 - e) Emergency room
 - f) Hospital
 - g) Don't know / Not sure
- 77) *[If prescribed antivirals since last survey]* For your most recent infection, what influenced your decision about taking an antiviral? Please select all that apply. (Source: V14)
- a) I was prescribed but did not take an antiviral [exclusive]
 - b) I felt ill
 - c) I was worried about severe outcomes like hospitalization
 - d) I was worried about getting long COVID
 - e) I thought it could help with long COVID symptoms
 - f) My doctor recommended and/or prescribed it
 - g) I believed it would be effective
 - h) It was within 5 days of symptom onset
 - i) It was convenient for me to get a prescription
 - j) I knew I was eligible for the antiviral
 - k) People I know had taken it
 - l) I felt that I had enough information about potential side effects
 - m) I could get it for free or at low cost
 - n) I felt comfortable with the FDA's emergency use authorization of the drug
 - o) I was not concerned that it would affect any other medications I was taking at the time
 - p) None of the above [exclusive]
 - q) Don't know/Not sure
- 78) *[If not prescribed antivirals since last survey and reported positive test in v15, OR if they said they were prescribed but did not take an antiviral in 'reasons for taking an antiviral' question]* For your most recent infection, what influenced your decision about **not** taking an antiviral? Please select all that apply. (Source: v14)
- a) My symptoms felt manageable without antiviral treatment
 - b) I didn't think I was at risk for severe outcomes like hospitalization
 - c) I was not worried about getting long COVID
 - d) I DIDN'T think it could help prevent my long COVID symptoms from getting worse
 - e) My doctor did not recommend it and/or would not prescribe it
 - f) I did not believe it would be effective

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- g) It was beyond 5 days of symptom onset
 - h) It was not convenient for me to get a prescription
 - i) I wasn't sure if I was eligible for the antiviral
 - j) No one I know had taken it
 - k) I didn't have enough information about potential side effects
 - l) I was worried about the cost
 - m) I was concerned about the lack of full FDA approval
 - n) I was concerned that it would affect other medications I was taking at the time
 - o) None of the above [exclusive]
 - p) Don't know/Not sure
- 79) *[If positive lab diagnosis in v15 or ever Covid in v15]* Thinking about the last time you had COVID, which of the following was true after your symptoms first began to improve? (Source: V14, updated in V15)
- a) My symptoms returned between 2 and 8 days later
 - b) I tested positive again between 2 and 8 days after a negative test
 - c) Both of the above
 - d) Neither of the above

Long-haul specific section

The following questions ask about experiences you may have had with COVID or long COVID.

Even if you do not currently have COVID or long COVID, it is important to us to collect this information to better understand the experiences of long COVID among participants.

- 80) *If skipped V4-14 or don't know/no in response to long-haul questions in V4-14:* 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-V14)
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 81) *If people haven't previously identified they have long-haul by a doctor in v10-14:* Have you been told by a **doctor** that you might have long COVID? (Source: C3, V10-12)

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

- a) Yes
- b) No

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- c) Don't know/not sure
- 82) 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, V11-14)
- a) Yes
 - b) No
 - c) Don't know / Not sure

- 83) *If yes or don't know to self-identified long-haul or told by a doctor or ONS, display:* The following question is about your experience with long-haul symptoms or long COVID.

When did your initial symptoms start? (Source: C3, V4-V14)

- a) December 2019
- b) ...
- c) June 2023

Adding skipping pattern: *If identified as long COVID (self, doctor, or ONS) in V15 or previously.*

The details of your experience with long COVID are important to us. This section may take a little more time to complete.

- 84) *If identified as long COVID (self, doctor, or ONS):* How would you describe your **long COVID** when it was the absolute worst?
- a) No impact on activities of daily living
 - b) Little impact on activities of daily living
 - c) Little to moderate impact on activities of daily living
 - d) Moderate impact on activities of daily living
 - e) Moderate to severe impact on activities of daily living
 - f) Severe impact on activities of daily living

- 85) 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.

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

- 86) *If ever had COVID in v15, positive lab test in v15 or long COVID (doctor, self, ONS) in any survey:* Since you had COVID, have you been diagnosed with any of the following medical conditions?
- a) Postural orthostatic tachycardia syndrome (POTS)

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- 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) Epstein Barr virus infection
 - m) Mononucleosis
 - n) Multiple sclerosis
 - o) Depression
 - p) Anxiety
 - q) Migraines
 - r) Abnormally elevated cholesterol or fats (lipids) in the blood (Dyslipidemia)
 - s) Insomnia
 - t) Traumatic brain injury
 - u) Other mental health diagnosis: _____
 - v) Anything else: _____
 - w) I have not been diagnosed with any of the above conditions
- 87) *If ever long Covid (self, doctor, ONS in any survey):* Compared to when you first got sick, how do you feel right now? (Source: C3, V4-V14)
- 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 next section*)
 - g) Don't know / Not sure
- 88) *If selected "Totally recovered" & identified as a long hauler in v14 or previously:* The following question is about your experience with long-haul symptoms or long COVID.
- 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

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- 89) *If reported at least one vaccine dose and id as having long haul (self or doctor or ONS):* Do you think your long-haul symptoms have improved since you were **vaccinated**? (Source: C3, V7-V14)
- a)
 - b) Yes
 - c) No
 - d) Don't know / Not sure
 - e) Not applicable
- 90) *If reported at least one booster and id as having long haul (self or doctor):* Do you think your long haul symptoms have improved since you were **boosted**? (Source: C3, V11-14)
- a)
 - b) Yes
 - c) No
 - d) Don't know / Not sure
 - e) Not applicable
- 91) *If yes to symptoms have improved since vaccination:* Which of your symptoms improved after being vaccinated? Please select all that apply. (Source: V14)
- 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) Difficulty sleeping
 - q) Something else: _____
 - r) No symptoms improved
- 92) *If yes to symptoms have improved since being boosted:* Which of your symptoms improved after being boosted? Please select all that apply. (Source: V14)
- a) Shortness of breath
 - b) Difficulty walking more than 15 minutes
 - c) Difficulty running/exercising
 - d) Fatigue

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- 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) Difficulty sleeping
 - q) Something else: _____
 - r) No symptoms improved
- 93) *If reported long-haul (self (C3 or ONS) or doctor) previously or in v15:* Have you tried any of the following for long-haul COVID symptoms? **Please select all that apply and/or feel free to list any additional treatments that are not included.** (Source: C3, V7-V14)
- a) Medication to reduce symptoms
 - b) Diet modifications
 - c) Physical therapy
 - d) Respiratory therapy (e.g. breathing exercises)
 - e) Respiratory assistance (e.g. inhaler, oxygen)
 - f) Occupational therapy
 - g) Monoclonal antibodies
 - h) Paxlovid (nirmatrelvir; ritonavir)
 - i) Lagevrio (molnupiravir)
 - j) COVID-19 vaccination
 - k) Vitamins or other herbal supplements
 - l) Other: _____
 - m) I didn't have symptoms (exclusive)
 - n) None of the above (exclusive)
- 94) *If yes to any resource:* did you find [prepopulate list of responses endorsed above, EXCLUDING 'I didn't have symptoms' and 'None of the above' a, n, o] helpful for reducing long-haul COVID symptoms?
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 95) *[If selected Paxlovid or Molnupiravir for long Covid]* Did your provider offer to prescribed you an antiviral or did you proactively request that they prescribed one for you?
- a) Provider offered

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- b) Proactively requested
 - c) Don't know / Not sure
- 96) *[If selected Paxlovid or Molnupiravir for long Covid]* Did your provider pause or change any **other** medications while you were taking an antiviral?
- a) Yes
 - b) No
 - c) Don't know / Not sure
- 97) *If reported long-haul (self (C3 or ONS)) OR DOCTOR ID previously or in v15:* Have you had difficulty finding a doctor to treat your long-haul COVID symptoms? (Source: C3, V7-V14)
- a) Yes
 - b) No
 - c) Don't know/not sure

Quality of Life

- 98) 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-V14, 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)

- 99) 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
- 100) 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
- 101) Usual activities (e.g. work, study, housework, family or leisure activities)

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- 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
- 102) 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
- 103) 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
- 104) 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. Use the slider to select the number to indicate how your health is TODAY. (Source: Euro Qol 5D)
[Scale from 0 to 100]
- 105) The next set of questions is about fatigue.

Please select the number between 1 and 7 which best fits the following statements. This refers to your usual way of life within **the last week**. 1 indicates “Strongly disagree” and 7 indicates “Strongly agree.” (Source: [Fatigue Severity Scale](#), recommended by CDC for long-haul evaluation. V11, 13)

- a) My motivation is lower when I am fatigued [1-7]
 - b) Exercise brings on my fatigue [1-7]
 - c) I am easily fatigued [1-7]
 - d) Fatigue interferes with my physical functioning [1-7]
 - e) Fatigue causes frequent problems for me [1-7]
 - f) My fatigue prevents sustained physical functioning [1-7]
 - g) Fatigue interferes with carrying out certain duties and responsibilities [1-7]
 - h) Fatigue is among my most disabling symptoms [1-7]
 - i) Fatigue interferes with my work, family, or social life [1-7]
- 106) 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

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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
 - c) Don't know / Not sure
- 107) 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
- 108) 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
- 109) 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
- 110) 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

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- e) Never
f) Don't know/Not sure
- 111) 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
- 112) Would you say that in general your health is: (Source: [CDC's Healthy Days Measure](#); C3: V2-V12)
a) Excellent
b) Very Good
c) Fair
d) Poor
- 113) 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](#))
a) _____ *Number of days from 1-30*
b) None
c) Don't know / Not sure
- 114) 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](#))
a) _____ *Number of days from 1-30*
b) None
c) Don't know / Not sure
- 115) 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](#))
a) _____ *Number of days from 1-30*
b) None
c) Don't know / Not sure
- 116) 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](#))
a) Yes
b) No
c) Don't know / Not sure

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- 117) How many times per week or per month did you take part in this activity during the **past month**? (Source: [BRFSS, 2019](#))
- a) ___ Times per week
 - b) ___ Times per month
 - c) Don't know / Not sure
- 118) And when you took part in this activity, for how many minutes or hours did you usually keep at it? (Source: [BRFSS, 2019](#))
- a) ___ Number of hours
 - b) ___ Number of minutes
 - c) Don't know / Not sure

Anxiety & Risk Perception

- 119) *If positive viral test or ever had COVID in V15:* How worried are you about getting sick from COVID-19 **again**? Would you say: (Source: C3, V3-V14. Updated v14)
- a) Not at all worried
 - b) Not too worried
 - c) Somewhat worried
 - d) Very worried
- 120) *If no positive test in v15 and never had COVID in V15:* How worried are you about getting sick from COVID-19? Would you say: (Source: C3, V0-V14. Updated v14)
- a) Not at all worried
 - b) Not too worried
 - c) Somewhat worried
 - d) Very worried
- 121) How worried are you about the long-term effects of a Covid-19 infection? (Source: V15)
- a) Not at all worried
 - b) Not too worried
 - c) Somewhat worried
 - d) Very worried
- 122) *If never previously reported long COVID (self, doctor, ONS) in this or earlier surveys:* How worried are you about getting long COVID? (Source: V15)
- a) Not at all worried
 - b) Not too worried
 - c) Somewhat worried
 - d) Very worried
- 123) **In the past month (since ADD Qualtrics DD/Mon/YY),** how often have you been bothered by the following problems (Source: GAD7, PHQ8)

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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				

Administrative

- 124) Would you like to receive the \$20 gift card incentive for your time participating in the survey?
- a) Yes
 - b) No

End Survey

Thank you for taking the time to complete this follow-up survey. If you opted to participate in the specimen collection, we hope to begin shipping the kits in a few weeks. You will hear from us in approximately three months with the next follow-up survey. In the interim, we may periodically reach out to invite you to participate in other studies you may be eligible for. A confirmation email with the details has also been sent to you.

For up to date and accurate information about COVID-19, please visit [CDC.gov](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html).

For up to date and accurate information about the COVID-19 vaccine, please visit <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>.

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



For questions or comments,
please email covid@sph.cuny.edu



**Follow-up Questionnaire for the
Communities, Households and SARS-CoV-2 Epidemiology (CHASING) COVID Study**
Version V15.0 | June 14, 2023

End survey [if not consented]

Thank you for participating in the Chasing Covid Cohort Study to date. You are no longer in the study and will not be asked to participate in future surveys or specimen collection.

If this was an error, please contact **us here: covid@sph.cuny.edu**

Automated Response

Thanks for completing this follow-up survey with the CHASING COVID Cohort study. If you requested the gift card, we will email you a \$20 *Tremendous* gift card to the email address that you provided within 3 business days.

As part of this longitudinal study on COVID, we can learn a lot from your experience and insights and appreciate your participation. The CHASING COVID Cohort study includes participants from all across the country.

If you have any questions about your participation in the study, or need to contact our team, email us at covid@sph.cuny.edu or call 917-740-8714.

Automated Response [NO TO CONSENT IN V15]

Thank you again for your participation in the CHASING COVID Cohort study so far. You have not consented to remain in the study, and will not be contacted for additional surveys or specimen collection.

If you have any questions or need to contact our team, email us at covid@sph.cuny.edu or call 917-740-8714.

END OF SURVEY

Fatigue Severity Scale - <https://www.sralab.org/rehabilitation-measures/fatigue-severity-scale>

Euro Qol 5D - <https://euroqol.org/publications/user-guides/>

Article on stigma <https://app.slack.com/client/T1AGTBN4C/D1BKYLU5S>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3758464/>

Symptom and Impact tool <https://pubmed.ncbi.nlm.nih.gov/33912905/>
<https://academic.oup.com/cid/article/74/2/278/6252414>