Study Questionnaire

Please complete the survey below.

Thank you!

Date:

_____

Participant's Name:

_____
((Last Name, First Name))

Address (of residence)

_____

Is the residence a:

- ◯ House
- ◯ Duplex home
- ◯ Apartment building
- ◯ Dorm

How many individuals live in the residence?

_____

Telephone

_____

Alternate telephone

_____

E-mail

_____

Case Demographics

Date of Birth:

_____

Age (in years):

_____

Sex:

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Unknown

If female, currently pregnant

- ◯ Yes
- ◯ No
- ◯ Unknown

Ethnicity:

- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Latino
- ◯ Unknown

Race (check all that apply):

- ☐ Black
- ☐ White
- ☐ Asian
- ☐ American Indian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Unknown

Civil State:

- ◯ Single
- ◯ Married
- ◯ Separated
- ◯ Divorced
- ◯ Widow
- ◯ Cohabitation

Education:

- ◯ Currently enrolled at university
- ◯ Associate degree
- ◯ Bachelor's degree
- ◯ Graduate or professional degree
- ◯ Doctorate

Healthcare Provider Information

Are you a healthcare provider in Puerto Rico?

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, what is your occupation?

- ◯ Physician
- ◯ Nurse
- ◯ Respiratory therapist
- ◯ Medical technologist
- ◯ Other

If other, specify

_____

If yes, what is your job setting?

- ◯ Hospital
- ◯ Long-term care facility
- ◯ Rehabilitation facility
- ◯ Clinical laboratory
- ◯ Nursing home/assisted living facility
- ◯ Other

If other, specify

_____

Exposure Information

	Yes	No
Are you currently sick?	◯	◯

In the 14 days prior to illness onset, did you have any of the following exposures? (Check all that apply.)

	Yes	No
Domestic travel (outside state of normal residence)	◯	◯
Cruise ship or vessel travel as passenger or crew member.	◯	◯
Workplace	◯	◯
Airport/airplane	◯	◯
Adult congregate living facility (nursing, assisted living, or long-term care facility)	◯	◯
School/university/childcare center	◯	◯
Community events/mass gathering	◯	◯
International travel	◯	◯
Contact with a known COVID-19 case (probable or confirmed)	◯	◯
Correctional facility	◯	◯
Animal with confirmed or suspected COVID-19	◯	◯

Domestic travel:

If yes, specify state(s). _____

Cruise ship or travel as passenger or crew member.

If yes, specify name of ship: _____

International travel:

If yes, specify country(ies). _____

Workplace

If yes, is the workplace critical infrastructure (e.g., healthcare setting, grocery store)? _____

If you had contact with a known COVID-19 case: What type of contact?

◯ Household contact
◯ Community-associated contact
◯ Healthcare-associated contact

Animal with confirmed or suspected COVID-19:

If yes, specify animal. _____

Unknown exposures in the 14 days prior to illness onset: _____

Other exposures, specify: _____

Use of Personal Protective Equipment

	Yes	No
Gown	◯	◯
Gloves	◯	◯
Surgical mask	◯	◯
N95 mask	◯	◯
Face shield	◯	◯
Hand washing while at work	◯	◯

Re-use gowns
◯ Yes
◯ No

Re-use gloves
◯ Yes
◯ No

Re-use surgical masks
◯ Yes
◯ No

Re-use N95 mask
◯ Yes
◯ No

Re-use Face shield
◯ Yes
◯ No

Gown:

If yes, how many hours per day? _____

Gloves:

If yes, how many hours per day? _____

Surgical mask:

If yes, how many hours per day? _____

N95 mask:

If yes, how many hours per day? _____

Face Shield:

If yes, how many hours per day? _____

Hand washing while at work:

If yes, how many hours per day?
◯ 0-5
◯ 6-10
◯ >11

If the answer to any of the above questions is no, please explain why:

_____

Exposure categories	◯ Are you a healthcare personnel who have had prolonged close contact with suspected/confirmed COVID-19 patients while NOT wearing personal protective equipment (PPE) ◯ Are you a healthcare personnel who had prolonged close contact with suspected/confirmed COVID-19 patients while wearing approved PPE ◯ Are you a healthcare personnel who had brief interactions with suspected/confirmed COVID-19 patients while wearing approved PPE

Compliance with infection prevention and control measures

Did you receive training related to infection control and prevention?	◯ Yes ◯ No
If yes, when did you receive training? (MM/DD/YYYY)	_____
How many hours of training did you receive?	◯ Less than 2 hours ◯ More than 2 hours
Do you follow the hygiene guidelines as recommended?	◯ Yes, as recommended ◯ Most of the time ◯ Occasionally ◯ Rarely
Do you use alcohol-based hand sanitizer or soap and water before touching each patient?	◯ Yes, as recommended ◯ Most of the time ◯ Occasionally ◯ Rarely
Do you use alcohol-based hand sanitizer or soap and water after touching each patient, their fluids, or their surroundings?	◯ Yes, as recommended ◯ Most of the time ◯ Occasionally ◯ Rarely
Is there enough personal protective equipment in your workplace?	◯ Yes ◯ No ◯ Unknown
Handwashing while in the workplace	◯ Yes ◯ No

Clinical Course, Symptoms, Past Medical History, and Social History

Have you experienced any symptoms in the past 2 weeks?	◯ Yes, symptomatic ◯ No symptoms
Onset date of symptoms (MM/DD/YYYY):	_____
If symptomatic, did your symptoms resolve?	◯ Yes ◯ No, still symptomatic ◯ Symptoms resolved, unknown date ◯ Unknown if symptoms resolved

If yes,

Date of symptom resolution (MM/DD/YYYY): _____

	Yes	No	Unknown	N/A
Did you develop pneumonia?	○	○	○	○
Did you have acute respiratory distress syndrome?	○	○	○	○
Did you have an abnormal chest X-ray?	○	○	○	○
Did you have another diagnosis/ etiology for the illness?	○	○	○	○
Did you have an abnormal EKG?	○	○	○	○
Did you receive extracorporeal membrane oxygenation?	○	○	○	○
Did you receive mechanical ventilation (MV)/intubation?	○	○	○	○

If yes,

Total days with MV: _____

If symptomatic, which of the following did you experience during the illness?

	Yes	No	Unknown
Fever >100.4F (38C)	○	○	○
Subjective fever (felt feverish)	○	○	○
Chills	○	○	○
Rigors	○	○	○
Muscle aches (myalgia)	○	○	○
Runny nose (rhinorrhea)	○	○	○
Sore throat	○	○	○
New olfactory and taste disorders	○	○	○
Headache	○	○	○
Fatigue	○	○	○
Joint pain	○	○	○
Nasal bleeding	○	○	○
Conjunctivitis	○	○	○
Cough (new onset or worsening of chronic cough)	○	○	○
Difficulty breathing	○	○	○
Chest pain	○	○	○

Nausea or vomiting	○	○	○
Abdominal pain	○	○	○
Diarrhea (>3 loose stools/24hr period)	○	○	○
Rash	○	○	○
Were you hospitalized?	○	○	○

Other symptoms? Specify: _____

If hospitalized:

Date of hospitalization (MM, DD, YYYY) _____

If hospitalized,

Specify the reason: _____

Do you have any of the following underlying medical condition and/or risk behaviors?

	Yes	No	Unknown
Diabetes	○	○	○
Hypertension	○	○	○
Severe obesity (BMI >40)	○	○	○
Cardiovascular disease	○	○	○
Chronic Renal disease	○	○	○
Chronic Liver disease	○	○	○
Arthritis	○	○	○
Chronic Lung disease (asthma/emphysema/COPD)	○	○	○
Immunosuppresive condition	○	○	○
Autoimmune condition	○	○	○
Current smoker	○	○	○
Former smoker	○	○	○
Second-hand smoker	○	○	○
Alcohol	○	○	○
Substance abuse or misuse	○	○	○
Disability (neurologic, physical, vision or hearing impairment	○	○	○
Psychological/psychiatric condition	○	○	○
Other chronic diseases	○	○	○
Other underlying condition or risk behavior	○	○	○

Diabetes:

If yes, specify type: _____

Disability:

If yes, specify: _____

Other Chronic disease:

If yes, which other chronic disease? _____

Other Underlying condition or risk behavior

If yes, specify: _____

Sample Collection

Choose a day for sample collection:
(Please choose a day Monday-Tuesday or Thursday-Friday) _____

Choose a time:
- ◯ 8:00am-12:00pm
- ◯ 1:00pm-2:30pm

COVID-19 Vaccination

	Yes	No
Are you vaccinated against ◯ COVID-19?	◯	

Which vaccine did you receive?
- ◯ Pfizer
- ◯ Moderna
- ◯ Johnson and Johnson

Date of First Dose _____

Date of Second Dose _____