Appendix A: CARE Survey
Baseline Survey

**Eligibility**

Do you currently live in the U.S.?
- Yes
- No

Are you over the age of 18?
- Yes
- No

NEXT
Eligibility

Does any of the following apply to you?

Have you gotten a COVID-19 vaccine?
- Yes
- No

Is it possible that you have been exposed to COVID-19?
- Yes
- No

Do you have symptoms that might be related to COVID-19?
- Yes
- No

Have you tested positive for COVID-19?
- Yes
- No
CONSENT TO PARTICIPATE

Adult: Consent to Use Data

Sponsor / Study Title: COVID-19: "Registries to study factors that may impact COVID-19 occurrence and severity"
Principal Investigator (Study Investigator): Nancy Dreyer, MPH, PhD, FGSP
Contact Information: info@helpstopcovidth.com

Thank you for your time. Please provide information about the study you will be participating in. By checking the box at the bottom of this form, you are confirming your choice to take part in this study.

Introduction and Purpose
You are being asked to participate in an observational research web-based study about COVID-19. This twelve-month study aims to understand the symptoms, treatments, and risk factors for COVID-19 illnesses as well as vaccine safety and effectiveness. The information collected may help researchers and other healthcare stakeholders learn more about COVID-19 symptoms, disease progression, protective, and risk factors.

Because COVID-19 is a new disease, very little is known about it and we are trying to collect information about the experience of people like you. We expect about 100,000 people to participate in this study, but there is no limit on the number of people who can participate.

There is no cost or compensation for participating in this study.

Who can take part in the study?
Any adult aged 18 or older who lives in the United States and has COVID-19, COVID-19-like symptoms, exposure to COVID-19, and/or COVID-19 vaccination is invited to participate. To participate, you must be willing and able to answer survey questions on either a computer, smartphone, or tablet that is

☐ I agree with terms & conditions

SUBMIT
PREVIOUS
Download
Partner Affiliation

Did you find out about this project from one of our partner organizations?

Start typing and select from list

SUBMIT
# Contact Information

What is your first name?  What is your last name?

Please enter your email.
This email address will be used to send you survey reminders and other study-related information.

d22_bern4@gmailinator.com

Please enter your mobile phone number (optional).
This information will be used to send you SMS notifications.

(XXX) XXX-XXXX

Zip Code

[PREVIOUS SECTION] [SUBMIT]
Alternate Contact (Optional)

Is there someone we could reach out to if you stop responding to follow up surveys?

This is completely optional. You do not need to provide an alternate contact to continue your participation. But in the event you stop responding to the follow up surveys, we want to be sure you are doing OK. We will only reach out to this person if we stop hearing from you. We promise not to spam them.

Name (optional)

Email address (optional)

PREVIOUS SECTION SUBMIT
Demographics

What is your gender?
- [ ] Man
- [ ] Transgender
- [ ] Woman
- [ ] Other identity
- [ ] Prefer not to disclose

Which of the following racial designations best describes you?
(Select all that apply)
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Other

Do you consider yourself Hispanic or Latino?
- [ ] Yes
- [ ] No
Demographics

Please enter your date of birth.

yyyy-MM-dd

What is your highest level of education?

- 8th grade or less
- Some high school, but did not graduate
- High school or GED
- Some college or 2-year degree
- 4-year college degree
- More than 4-year college degree
Vaccine

Did you receive a COVID-19 vaccine?
- Yes
- No
- I don’t know

Has your doctor advised you not to get a COVID-19 vaccine?
For example, on account of pre-existing medical conditions.
- Yes
- No
Vaccine

Did you receive a COVID-19 vaccine?

- Yes
- No
- I don't know

Did you receive a COVID-19 vaccine as part of a clinical trial?

- Yes
- No
# Vaccine

**Did you receive a COVID-19 vaccine?**
- [ ] Yes
- [ ] No
- [ ] I don’t know

**Did you receive a COVID-19 vaccine as part of a clinical trial?**
- [ ] Yes
- [ ] No

**Date of first COVID-19 vaccine:**
If you don’t remember the exact date, please enter your best guess.

- [yyyy-MM-dd]

**Who was the vaccine manufacturer?**
The vaccine manufacturer is the company who made the vaccine. It should be noted on a receipt, form, or card you received when you got the vaccine.

- [Start typing and select from list]

**What was the lot number?**
The lot number should be noted on your vaccination card.

- []
Vaccine

We are now going to ask about your experience after your first COVID-19 vaccine. If you received a booster or a second dose, we will ask about that later.

After you had the vaccine, did you experience any of the following? (Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)
- I haven't experienced any of those after my vaccine.
After your vaccine, did you have any other side-effects or symptoms that aren't listed above?

Yes  No
Vaccine

We are now going to ask about your experience after your first COVID-19 vaccine. If you received a booster or a second dose, we will ask about that later.

After you had the vaccine, did you experience any of the following:
(Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)

How would you rate your pain at its worst?

- Very Mild
- Mild
- Moderate
- Severe
About how many days have you experienced pain, redness or swelling where the shot was given?
If you aren’t sure, please use your best guess.
Type days

Is your pain, redness or swelling where the shot was given ongoing?
Yes  No

After your vaccine, did you have any other side-effects or symptoms that aren’t listed above?
Yes  No

What other side-effects or symptoms did you experience?
Please select ‘Add’ button to enter additional symptom.

What side-effect or symptom?

How would you rate your symptom at its worst?
Very Mild  Mild
Moderate  Severe

About how many days have you experienced symptom?

Is your symptom ongoing?
Yes  No

Add +
### Vaccine

After the vaccine, did you have any trouble taking care of yourself (such as bathing, dressing) because of these symptoms?

- [ ] Not at all
- [ ] A little
- [ ] Somewhat
- [ ] Quite a bit
- [ ] A lot

After the vaccine, did you miss work or work less because of these symptoms?

- [ ] No, I have been able to perform normal work activities
- [ ] Yes, I missed work or worked less due to my symptoms
- [ ] Not applicable, I'm not employed

After the vaccine, how many days of work did you miss due to these symptoms?

   In other words, days you were not able to work at all.

   [ ]

After the vaccine, how many days did you work less because of these symptoms?

   In other words, days when you were able to work, but not at your normal level or number of hours.

   [ ]

Did you seek medical care for any of these symptoms?

- [ ] Yes
- [ ] No

Were you hospitalized due to these symptoms?

- [ ] Yes
- [ ] No
**Vaccine**

After your first COVID-19 vaccine, did you get any additional COVID-19 shots (e.g., a 2nd dose or booster)?

This vaccine could be a 2nd dose of Pfizer or Moderna or an additional booster after you got 1 shot of Astra or 2 shots of Moderna or Pfizer.

- Yes
- No

Has your doctor advised you not to get additional COVID-19 vaccines or boosters?

- Yes
- No
## Vaccine

**After your first COVID-19 vaccine, did you get any additional COVID-19 shots (e.g., a 2nd dose or booster)?**

This vaccine could be a 2nd dose of Pfizer or Moderna or an additional booster after you get 1 dose of J&J or 2 shots of Novavax or Astra.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**How many additional COVID-19 vaccines/boosters did you get after your first shot?**

Select the number of boosters

Next
Vaccine

Please enter information about your 1st COVID-19 vaccine.

Date of the vaccine:
If you don't remember the exact date, please enter your best guess.
Vaccine dates and manufacturers you have told us about so far:
2021-10-01 Pfizer

yyyy-MM-dd

Who was the manufacturer for the vaccine?
The vaccine manufacturer is the company who made the vaccine. It should be noted on your receipt, form, or card you received when you got the vaccine.
Start typing and select from list

What was the lot number?
The lot number should be noted on your vaccination card.

We are now going to ask about your experience after your 1st vaccine.

After you had the vaccine, did you experience any of the following?
(Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea

- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)
- I haven't experienced any of these after my vaccine.

PREVIOUS SUBMIT
We are now going to ask about your experience after your 1st vaccine.

After you had the vaccine, did you experience any of the following? (Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)

How would you rate your fever at its worst?

- Very Mild
- Mild
- Moderate
- Severe
About how many days have you experienced fever?
If you aren’t sure, please use your best guess.
Type days

Is your fever ongoing?
Yes  No

After your vaccine, did you have any other side-effects or symptoms that aren’t listed above?
Yes  No

What other side-effects or symptoms did you experience?
Please select “Add” button to enter additional symptom.

What side-effect or symptom?

How would you rate your symptom at its worst?
Very Mild  Mild  Moderate  Severe

About how many days have you experienced symptom?
Type days

Is your symptom ongoing?
Yes  No
After this vaccine, did you have any trouble taking care of yourself (such as bathing, dressing) because of these symptoms?
- Not at all
- A little
- Somewhat
- Quite a bit
- A lot

After this vaccine, did you miss work or work less because of these symptoms?
- No, I have been able to perform normal work activities
- Yes, I missed work or worked less due to my symptoms
- Not applicable, I'm not employed

After this vaccine, how many days of work did you miss due to these symptoms?
In other words, days you were not able to work at all.

After this vaccine, how many days did you work less because of these symptoms?
In other words, days when you were able to work, but not at your normal level or number of hours.

Did you seek medical care for any of these symptoms?
- Yes
- No

Were you hospitalized due to these symptoms?
- Yes
- No
Date hospitalized

yyyy-MM-dd

How long were you hospitalized? Please answer in days.

PREVIOUS SUBMIT
Testing

In the past two weeks, have you been tested for COVID-19?

Yes  No

Please provide information about your COVID-19 test(s). Select “Add” button to report additional COVID-19 tests.

Note: this does not include antibody tests, we will ask about those later.

Please enter the date of testing.

YYYY-MM-DD

What was the result?

Positive  Negative  Awaiting results

What type of COVID-19 test did you take?

Molecular test (also called PCR test, with results within a day or up to a week)

Antigen test (also called rapid test that is often done at your doctor’s office with results within an hour)

I don’t know

ADD +

PREVIOUS SECTION  NEXT
Testing

Have you ever tested positive for COVID-19?
Note: This does not include antibody tests. We will ask about those later.

- Yes
- No

Please enter the date of testing.
If you had multiple positive COVID-19 tests, please enter the date of your first positive test to the best of your memory.

YYYY-MM-DD

What type of COVID-19 test did you take?
If you had multiple positive COVID-19 tests, please enter the type of test for your first positive test.

- Molecular test (also called PCR test, with results within a day or up to a week)
- Antigen test (also called rapid test that is often done at your doctor's office with results within an hour)
- I don't know
Testing

Have you taken a COVID-19 ANTIBODY test and if so, what was the result?
This may also be referred to as a serum test and is intended to know if you ever had COVID-19:

- **No, I have not taken a COVID-19 antibody test**
- **Yes, I took a COVID-19 antibody test and it was positive**
- **Yes, I took a COVID-19 antibody test and it was negative**
- **Yes, I took a COVID-19 antibody test and am awaiting results**

Please enter the date of testing.

/yyyy-MM-dd

Does anyone in your household have COVID-19 or an influenza-like illness?

- **Yes**
- **No**

Did they test positive for COVID-19?
In other words, is it a confirmed COVID-19 case?

- **Yes**
- **No**
### Symptoms

Have you had any of the following today?  
(Select all that apply)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue (feeling tired)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath/Difficulty breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurry vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aches and pains</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle twitching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash or itchy or burning skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal congestion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased sense of taste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased sense of smell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent pain or pressure in the chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart palpitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling disoriented or having trouble thinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble waking up after sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia or trouble sleeping</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I am not experiencing any of these symptoms.
**Symptoms**

Have you had any of the following today?  
(Select all that apply)

Please select any symptoms you may have experienced.

- Fever
- Chills
- Cough
- Fatigue (feeling tired)
- Shortness of breath/Difficulty breathing
- Headache
- Dizziness
- Eye pain
- Blurry vision
- Aches and pains
- Muscle twitching
- Rash or itchy or burning skin
- Nasal congestion
- Runny nose
- Sore throat
- Decreased sense of taste
- Decreased sense of smell
- Decreased appetite
- Nausea
- Vomiting
- Diarrhea
- Persistent pain or pressure in the chest
- Heart palpitations
- Feeling disoriented or having trouble thinking
- Trouble waking up after sleeping
- Depression
- Anxiety
- Insomnia or trouble sleeping
I am not experiencing any of these symptoms.

You previously reported a positive COVID-19 test, do you currently have any other symptoms you think may be related to COVID-19 that are not listed above?

Yes  No

What other symptoms are you currently experiencing?
Please select "Add" button to enter additional symptoms.

Name of symptom:

How would you rate your symptom today at its worst?

Very Mild  Mild  Moderate  Severe

ADD +

PREVIOUS SECTION  NEXT
### Symptoms

Have you had any of the following today?  
(Select all that apply)

- [ ] Fever
- [ ] Chills
- [ ] Cough
- [ ] Fatigue (feeling tired)
- [ ] Shortness of breath/Difficulty breathing
- [ ] Headache
- [ ] Dizziness
- [ ] Eye pain
- [ ] Blurry vision
- [ ] Aches and pains
- [ ] Muscle twitching
- [ ] Rash or itchy or burning skin
- [ ] Nasal congestion
- [ ] Runny nose
- [ ] Sore throat
- [ ] Decreased sense of taste
- [ ] Decreased sense of smell
- [ ] Decreased appetite
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Persistent pain or pressure in the chest
- [ ] Heart palpitations
- [ ] Feeling disoriented or having trouble thinking
- [ ] Trouble waking up after sleeping
- [ ] Depression
- [ ] Anxiety
- [ ] Insomnia or trouble sleeping
**Symptoms**

How difficult was it to take care of yourself today (such as bathing, dressing) because of your symptoms?

- Not at all
- A little
- Somewhat
- Quite a bit
- A lot

Are you currently able to perform your normal work activities?

- Yes, I am able to perform normal work activities
- No, I'm unable to work due to my symptoms
- No, I'm working less due to my symptoms
- No, I'm not back to my normal work activities due to reasons other than my symptoms (such as quarantine, childcare/caregiver, holiday, etc)
- Not applicable, I'm not employed

Do you feel like you are at your normal health today?

- Yes
- No
Symptoms

In the past 2 weeks, have you seen a doctor or a healthcare provider? This includes Telehealth visits or phone calls.

Yes  No

Please provide information about your visit. Select "Add" button to report additional visits.

Type of visit:
- Telehealth visit
- In-person doctor's office visit
- Urgent care
- Emergency room
- Admitted to hospital
- I'm not sure

How long were you hospitalized? Please answer in days.

Date of visit:

yyyy-MM-dd
Was this visit related to a confirmed or possible COVID-19 infection?

- Yes
- No
- I'm not sure
**Treatment**

You previously reported a positive COVID-19 test, are you currently taking any medications (prescription or non-prescription) to prevent or treat COVID-19 symptoms?

There will be an opportunity to enter medications you are taking to treat other conditions later.

- [ ] Yes
- [x] No

Which medications?

You can enter multiple medications.

Start typing and select from list

[PREVIOUS SECTION] [SUBMIT]
Medical History

Height (feet)

Height (inches)

Weight (pounds)
Medical History

Are you pregnant?

- Yes
- No

When is your due date?
If you don't know your due date, please enter your best guess.

yyyy-MM-dd

PREVIOUS
NEXT
Medical History

Are you a current smoker?
- Yes
- No

Did you get a flu shot this flu season?
- Yes
- No
Medical History

Do you have any of the below? (Select all that apply)

- Depression
  (This includes a diagnosis of depression or bipolar.)

- Anxiety
  (This includes a diagnosis of anxiety, obsessive compulsive disorder (OCD), or post-traumatic stress disorder (PTSD))

- Insomnia or trouble sleeping
  (This is when you have trouble falling and staying asleep at night.)

- Heart disease, stroke or another cardiovascular disease

- Chronic kidney disease, kidney stones, or another kidney disease

- High blood pressure
  (also known as hypertension)

- Diabetes
  (Type 1 or Type 2)

- Rheumatoid arthritis, psoriasis, multiple sclerosis, Crohn's, or another autoimmune disease

- Moderate to severe asthma, COPD, emphysema, or another lung disease

- Seasonal allergies

- Allergic reactions to medications or vaccines

- Heartburn or ulcers

- Blood clots, sickle cell, thalassemia, thrombocytopenia, or another blood disease

- Organ transplant

- None of the above
Are you currently being treated for cancer?

Yes  No

Are you taking any other prescription medications? Other than the ones you've already told us about.

Yes  No
Medical History

Do you have any of the below?
(Select all that apply)

- **Depression**
  (This includes a diagnosis of depression or bipolar.)

- **Anxiety**
  (This includes a diagnosis of anxiety, obsessive compulsive disorder (OCD), or post-traumatic stress disorder (PTSD).)

- **Insomnia or trouble sleeping**
  (This is when you have trouble falling and staying asleep at night.)

- **Heart disease, stroke or another cardiovascular disease**

- **Chronic kidney disease, kidney stones, or another kidney disease**

- **High blood pressure**
  (also known as hypertension)

- **Diabetes**
  (Type 1 or Type 2)

- **Rheumatoid arthritis, psoriasis, multiple sclerosis, Crohn’s, or another autoimmune disease**

- **Moderate to severe asthma, COPD, emphysema, or another lung disease**

- **Seasonal allergies**

- **Allergic reactions to medications or vaccines**

- **Heartburn or ulcers**

- **Blood clots, sickle cell, thalassemia, thrombocytopenia, or another blood disease**

- **Organ Transplant**
Are you currently being treated for cancer?
- Yes
- No

Are you currently taking prescription or over the counter medication to treat your depression?
- Yes
- No

Which prescription medication?
You can enter multiple medications.
Start typing and select from list

Which over the counter medications?
You can enter multiple medications.
Start typing and select from list

Are you taking any other prescription medications? Other than the ones you've already told us about.
- Yes
- No

Which prescription medications?
You can enter multiple medications.
Start typing and select from list
Medical History

In the past 3 months, have you regularly taken any of the below vitamins or supplements? (Select all that apply)

- Vitamin D
- Vitamin C
- Zinc
- Elderberry
- Garlic
- Glucosamine
- Multi-vitamin/supplement
- Other
Follow Up Survey

Vaccine

Since you last completed the survey, did you get any additional COVID-19 shots (e.g., a 2nd dose or booster)?
This vaccine could be a 2nd dose of Pfizer or Moderna or an additional booster after you get 1 shot of J&J or 3 shots of Moderna or Pfizer.

- Your last survey response: Yes
  - Yes
  - No

Has your doctor advised you not to get additional COVID-19 vaccines or boosters?

- Your last survey response: No response
  - Yes
  - No
Vaccine

Since you last completed the survey, did you get any additional COVID-19 shots (e.g., a 2nd dose or booster)?

Your last survey response: Yes

How many additional COVID-19 vaccines/boosters did you get after your first shot?

Your last survey response: 1

Select the number of boosters

Submit
**Vaccine**

**Please enter information about your 3rd COVID-19 vaccine.**

**Date of the vaccine:**
If you don't remember the exact date, please enter your best guess.

Vaccine dates and manufacturers you have told us about so far:
- 2021-10-21, Pfizer
- 2021-10-30, Pfizer

**Who was the manufacturer for the vaccine?**
The vaccine manufacturer is the company who made the vaccine. It should be noted on a recall list, form, or card you received when you got the vaccine.

Start typing and select from list

**What was the lot number?**
The lot number should be noted on your vaccination card.

[Field for lot number]
We are now going to ask about your experience after your 3rd COVID-19 vaccine.

After you had the vaccine, did you experience any of the following?
(Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)
- I haven't experienced any of these after my vaccine.

Submit
We are now going to ask about your experience after your 3rd COVID-19 vaccine.

After you had the vaccine, did you experience any of the following:
(Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)

How would you rate your headache at its worst?

- Very Mild
- Mild
- Moderate
- Severe
About how many days have you experienced headache?
If you aren't sure, please use your best guess.
Type days

Is your headache ongoing?
Yes  No

After your vaccine, did you have any other side-effects or symptoms that aren't listed above?
Yes  No

What other side-effects or symptoms did you experience?
Please select “Add” button to enter additional symptom.

What side-effect or symptom?

How would you rate your symptom at its worst?
Very Mild  Mild  Moderate  Severe

About how many days have you experienced symptom?
Type days

Is your symptom ongoing?
Yes  No

ADD +
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>After this vaccine, did you have any trouble taking care of yourself</td>
<td>Not at all, A little, Somewhat, Quite a bit, A lot</td>
</tr>
<tr>
<td>(such as bathing, dressing) because of these symptoms?</td>
<td></td>
</tr>
<tr>
<td>After this vaccine, did you miss work or work less</td>
<td>No, I have been able to perform normal work activities</td>
</tr>
<tr>
<td>because of these symptoms?</td>
<td>Yes, I missed work or worked less due to my symptoms</td>
</tr>
<tr>
<td></td>
<td>Not applicable, I’m not employed</td>
</tr>
<tr>
<td>After this vaccine, how many days of work did you miss</td>
<td></td>
</tr>
<tr>
<td>due to these symptoms?</td>
<td>In other words, days you were not able to work at all.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>After this vaccine, how many days did you work less</td>
<td></td>
</tr>
<tr>
<td>because of these symptoms?</td>
<td>In other words, days when you were able to work, but not at your normal</td>
</tr>
<tr>
<td></td>
<td>level or number of hours.</td>
</tr>
<tr>
<td>Did you seek medical care for any of these symptoms?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Were you hospitalized due to these symptoms?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
**Date hospitalized**

yyyy-MM-dd

**How long were you hospitalized? Please answer in days.**


Vaccine

We are now going to ask about your experience after "Pfizer" vaccine received on 2021-10-02.

After you had the vaccine, did you experience any of the following? (Select all that apply)

- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)
- I haven't experienced any of these after my vaccine.

After your vaccine, did you have any other side-effects or symptoms that aren't listed above?

[ ] Yes  [ ] No
Vaccine

We are now going to ask about your experience after "Pfizer" vaccine received on 2021-10-02.

After you had the vaccine, did you experience any of the following?
(Select all that apply)
- Pain, redness, itching or swelling where the shot was given
- Swollen lymph nodes (such as swollen glands, may be in your armpit, neck, or other parts of your body)
- Fever
- Fatigue
- Chills
- Headache
- Dizziness, lightheadedness, or vertigo
- Brain fog
- New or worsening joint pain
- New or worsening muscle pain
- Nausea or Vomiting
- Diarrhea
- Severe allergic reaction (such as swelling of lips or tongue, shortness of breath, severe hives)
How would you rate your fatigue at its worst?

- Very Mild
- Mild
- Moderate
- Severe

About how many days have you experienced fatigue?
If you aren't sure, please use your best guess.

- Type days

Is your fatigue ongoing?

- Yes
- No

After your vaccine, did you have any other side-effects or symptoms that aren't listed above?

- Yes
- No

What other side-effects or symptoms did you experience? Please select "Add" button to enter additional symptom.

What side-effect or symptom?

How would you rate your symptom at its worst?

- Very Mild
- Mild
- Moderate
- Severe

About how many days have you experienced symptom?

Is your symptom ongoing?

- Yes
- No
### Vaccine

**After the vaccine, did you have any trouble taking care of yourself (such as bathing, dressing) because of these symptoms?**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>A lot</th>
</tr>
</thead>
</table>

**After the vaccine, did you miss work or work less because of these symptoms?**

<table>
<thead>
<tr>
<th></th>
<th>No, I have been able to perform normal work activities</th>
<th>Yes, I missed work or worked less due to my symptoms</th>
<th>Not applicable, I'm not employed</th>
</tr>
</thead>
</table>

**After the vaccine, how many days of work did you miss due to these symptoms?**

In other words, days you were not able to work at all.

**After the vaccine, how many days did you work less because of these symptoms?**

In other words, days you were able to work, but not at your normal level or number of hours.
Did you seek medical care for any of these symptoms?
Yes  No

Were you hospitalized due to these symptoms?
Yes  No

Date hospitalized
YYYY-MM-dd

How long were you hospitalized? Please answer in days.

PREVIOUS  SUBMIT
Testing

Since you last completed the survey, have you been tested for COVID-19?

- Your last survey response: Yes
- No

Please provide information about your COVID-19 test(s). Select “Add” button to report additional COVID-19 tests.

Note: This does not include antibody tests, we will ask about those later.

Your last survey response:
2021-10-03, Positive, Molecular test (also called PCR test, with results within a day or up to a week)

Please enter the date of testing.

yyyy-MM-dd

What was the result?

- Positive
- Negative
- Awaiting results

What type of COVID-19 test did you take?

- Molecular test (also called PCR test, with results within a day or up to a week)
- Antigen test (also called rapid test that is often done at your doctor's office with results within an hour)
- I don't know

ADD +
Testing

Since you last completed the survey, have you taken a COVID-19 antibody test and if so, what was the result?
This may also be referred to as a serum test and is intended to show if you ever had COVID-19.

☐ Your last survey response: No, I have not taken a COVID-19 antibody test

☐ No, I have not taken a COVID-19 antibody test

☐ Yes, I took a COVID-19 antibody test and it was positive

☐ Yes, I took a COVID-19 antibody test and it was negative

☐ Yes, I took a COVID-19 antibody test and am awaiting results

Please enter the date of testing.

☐ Your last survey response: No response

xxxx-MM-dd

Since you last completed the survey, does anyone in your household have COVID-19 or an influenza-like illness?

☐ Your last survey response: No

☐ Yes

☐ No

Did they test positive for COVID-19?
In other words, is it a confirmed COVID-19 case?

☐ Your last survey response: No response

☐ Yes

☐ No

Submit
Symptoms

Now we are going to ask you some questions about your potential COVID-19 related symptoms because we are very interested in how your symptoms have changed.

Have you had any of the following today? (Select all that apply)

Please select any symptoms you may have experienced.  

- Your last survey response: Fatigue (feeling tired)

- Fever
- Chills
- Cough
- Fatigue (feeling tired)
- Shortness of breath/Difficulty breathing
- Headache
- Dizziness
- Eye pain
- Blurry vision
- Aches and pains
- Muscle twitching
- Rash or itchy or burning skin
- Nasal congestion
- Runny nose
- Sore throat
- Decreased sense of taste
- Decreased sense of smell
- Decreased appetite
- Nausea
- Vomiting
- Diarrhea
- Persistent pain or pressure in the chest
- Heart palpitations
- Feeling disoriented or having trouble thinking
- Trouble waking up after sleeping
- Depression
- Anxiety
- Insomnia or trouble sleeping
- I am not experiencing any of these symptoms.
**Symptoms**

Now we are going to ask you some questions about your potential COVID-19 related symptoms because we are very interested in how your symptoms have changed.

**Have you had any of the following today?**
(Select all that apply)

- Fever
- Chills
- Cough
- Fatigue (feeling tired)
- Shortness of breath/Difficulty breathing
- Headache
- Dizziness
- Eye pain
- Blurry vision
- Aches and pains
- Muscle twitching
- Rash or itchy or burning skin
- Nasal congestion
- Runny nose
- Sore throat
- Decreased sense of taste
- Decreased sense of smell
- Decreased appetite
- Nausea
- Vomiting
- Diarrhea
- Persistent pain or pressure in the chest
- Heart palpitations
- Feeling disoriented or having trouble thinking
You previously reported a positive COVID-19 test, do you currently have any other symptoms you think may be related to COVID-19 that are not listed above?

Your last survey response: No

Yes  No

What other symptoms are you currently experiencing?

Please select "Add" button to enter additional symptoms.

Your last survey response: No response

Name of symptom:

How would you rate your symptom today at its worst?

Very Mild  Mild  Moderate  Severe

Add +

PREVIOUS SECTION  NEXT
Symptoms

How would you rate your diarrhea today at its worst?

- Very Mild
- Mild
- Moderate
- Severe

Overall, how have your symptoms changed from the last time you answered the survey?

- Improved
- Worsened
- Stayed about the same
- I did not report any symptom last time
Symptoms

How difficult was it to take care of yourself today (such as bathing, dressing) because of your symptoms?

- Your last survey response: Not at all
  - Not at all
  - A little
  - Somewhat
  - Quite a bit
  - A lot

Are you currently able to perform your normal work activities?

- Your last survey response: Yes, I am able to perform normal work activities
  - Yes, I am able to perform normal work activities
  - No, I'm unable to work due to my symptoms
  - No, I'm working less due to my symptoms
  - No, I'm not back to my normal work activities due to reasons other than my symptoms (such as quarantine, childcare/caregiver, holiday, etc)
  - Not applicable, I'm not employed

Do you feel like you are at your normal health today?

- Your last survey response: No
  - Yes
  - No
Treatment

Now we are going to ask you some questions about your treatments because we are very interested in how your treatments and medications have changed.

You previously reported a positive COVID-19 test, are you currently taking any medications (prescription or non-prescription) to prevent or treat COVID-19 symptoms?

Please enter new medications as well as medications you reported last time and continue to take for COVID-19.

☑️ Your last survey response: Yes

☑️ Yes
☑️ No

Which medications?
You can enter multiple medications.

☑️ Your last survey response: Advil (Oral Pill)

Start typing and select from list:

PREVIOUS SECTION

SUBMIT
Medical History

Our application has detected that we don’t have complete medical history data. Please take a few minutes and provide your current medical history details.

Since you last completed the survey, has there been any changes to your medical history?
For example, your medications, diagnoses, flu vaccine, pregnancy.

Yes  No

PREVIOUS SECTION  NEXT
Medical History

Since you last completed the survey, has there been any changes to your medical history?
For example, any medications, diagnoses, flu, vaccine, pregnancy.

Yes  No

We will assume that your medical history data that you reported last time is current and up-to-date. If you are not sure of the last reported data, please select Yes to see all your earlier responses.

PREVIOUS SECTION  SUBMIT
Medical History

Since you last completed the survey, has there been any changes to your medical history?
For example, your medications, diagnoses, flu vaccine, pregnancy.

Yes  No
Medical History

Are you pregnant?

☑️ Your last survey response: No

- [ ] Yes
- [x] No

[PREVIOUS] [NEXT]
Medical History

Are you pregnant?
- Your last survey response: No
- Yes
- No

When is your due date?
If you don't know your due date, please enter your best guess.
- Your last survey response: No response
  - yyyy-MM-dd

PREVIOUS NEXT
Medical History

Are you a current smoker?
- Your last survey response: No
  - Yes
  - No

Did you get a flu shot this flu season?
- Your last survey response: No
  - Yes
  - No
<table>
<thead>
<tr>
<th>Medical History</th>
</tr>
</thead>
</table>
| **Do you have any of the below?**  
(Select all that apply) |
| ![Add a list of medical conditions]
| **Depression**  
(This includes a diagnosis of depression or bipolar.) |
| **Anxiety**  
(This includes a diagnosis of anxiety, obsessive compulsive disorder (OCD), or post-traumatic stress disorder (PTSD).) |
| **Insomnia or trouble sleeping**  
(This is when you have trouble falling and staying asleep at night.) |
| **Heart disease, stroke or another cardiovascular disease** |
| **Chronic kidney disease, kidney stones, or another kidney disease** |
| **High blood pressure**  
(also known as hypertension) |
| **Diabetes**  
(Typ 1 or Typ 2) |
| **Rheumatoid arthritis, psoriasis, multiple sclerosis, crohn's, or another autoimmune disease** |
| **Moderate to severe asthma, COPD, emphysema, or another lung disease** |
| **Seasonal allergies** |
| **Allergic reactions to medications or vaccines** |
| **Heartburn or ulcers** |
| **Blood clots, sickle cell, thalassemia, thrombocytopenia, or another blood disease** |
| **Organ Transplant** |
Are you currently being treated for cancer?
- Your last survey response: No
  - Yes
  - No

Are you currently taking prescription or over the counter medication to treat your depression?
- Your last survey response: Yes
  - Yes
  - No

Which prescription medication?
- You can enter multiple medications.
  - Your last survey response: PROZAC (Oral Pill)
    - Start typing and select from list

Which over the counter medications?
- You can enter multiple medications.
  - Your last survey response: TYLENOL (Oral Pill)
    - Start typing and select from list

Are you taking any other prescription medications? Other than the ones you've already told us about.
- Your last survey response: Yes
  - Yes
  - No

Which prescription medications?
- You can enter multiple medications.
  - Your last survey response: Omeprazole (Oral Pill)
    - Start typing and select from list
Medical History

In the past 3 months, have you regularly taken any of the below vitamins or supplements? (Select all that apply)

- Vitamin D
- Vitamin C
- Zinc
- Elderberry
- Garlic
- Glucosamine
- Multi-vitamin/supplement
- Other

Your last survey response: Multi-vitamin/supplement