

Study Title: Prevalence of SARS-CoV-2 in Healthcare workers in the early stages of the pandemic

Appendix 1

Demographic data

Participant study Code (to be filled in by researchers): _____

Date: _____

Age _____

Gender _____

Healthcare occupation _____

Healthcare location e.g. ED, ward _____

COVID-19 contact risk _____

Weight _____

Height _____

Participant co-morbidities; please tick

I have already had to stay overnight in a hospital because of COVID-19	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am a smoker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am an ex-smoker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have high blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have COPD/emphysema/bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have heart disease (for example: angina/previous heart attack/stents/heart bypass surgery/heart failure)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have other metabolic conditions apart from diabetes (such as thyroid disease)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have Chronic Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have Chronic Liver Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have immunosuppression (from medications like chemotherapy or biological agents, or from infection)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have a blood disorder (such as Leukaemia, Haemophilia etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have an active cancer diagnosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have a Neurological condition (such as Epilepsy or Stroke)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I don't have any of the above risk factors or medical conditions	Yes <input type="checkbox"/>	No <input type="checkbox"/>

| Name (Block Capitals)

| Participant Signature

| Date