Ver. 1

WHI COVID-19 Survey 2

OFFICE USE ONLY

1. Date received: ____/____/_____
MM DD YYYY

2. Reviewed by: 80-__ __ __ __ __

○ RCR ○ OU1 ○ OU2

Participant ID Label

Please use a pencil or blue or black pen only to complete this form.

Some of the questions below refer to the time you last provided information on COVID-19. You completed that questionnaire on:

Date Label

Throughout this questionnaire, you will be asked about your experiences that relate to the current COVID-19 pandemic. We use the term COVID-19 to refer to the illness caused by the novel coronavirus that was first identified in 2019 and is also called SARS-CoV-2.

Today's date: ____/____/_____
MM DD YYYY

SECTION ONE:

1. Who is completing this form?

○ 1 Self (WHI Study participant)

○ 2 Other, on behalf of the WHI participant
Name and relationship to participant:
_____

2. What is the zip code where you are currently living?_____

3. When you think about well-being, think about your physical health, your emotional health, any challenges you are experiencing, the people in your life, and the opportunities or resources available to you. How would you describe your current level of well-being?

○ 1 Excellent
○ 2 Very Good
○ 3 Good
○ 4 Fair
○ 5 Poor
○ 6 Very Poor

PLEASE MAKE NO MARKS IN THIS AREA

4. Since the date of your last survey, given on page 1, have your living arrangements, including the place where you live and the people who live with you, changed due to the COVID-19 pandemic?

○ 0 No → **Go to Question 5.** ○ 1 Yes → **Go to Question 4.1.**

4.1 What has changed in your living arrangements? **Mark all that apply.**

- ○ 1 I moved to live with other family members or friends
- ○ 2 Other family or friends moved in with me
- ○ 3 Some household members moved away to limit the possibility of infection
- ○ 4 I moved out of shared housing to limit the possibility of infection
- ○ 5 A care provider/companion now comes to help me
- ○ 6 My care provider/companion no longer comes to help me
- ○ 7 I have moved into a care facility
- ○ 8 I have moved out of a care facility
- ○ 9 Other, specify: _____

5. Do you live in a private home?

○ 1 Yes ○ 0 No → **Go to Question 5.2.**

↓

5.1 Including yourself, how many people currently live in your household?

○ 1 1 ○ 2 2 ○ 3 3 ○ 4 4 ○ 5 5 or more

5.2 Are any of the services and/or restrictions listed below in place where you currently live as a result of the COVID-19 pandemic? **Mark all that apply.**

- ○ 1 Residents are not allowed to leave their home/apartment/room
- ○ 2 Residents are not allowed to have visitors
- ○ 3 Residents are not allowed to leave the property except for emergencies
- ○ 4 Food is delivered to the home/apartment/room
- ○ 5 There are no restrictions on residents

6. Has anyone in your family or a close friend died from COVID-19?

○ 1 Yes ○ 0 No → **Go to Question 7.**

↓

6.1 Who have you lost to COVID-19? **Mark all that apply.**

- ○ 1 Spouse or partner
- ○ 2 Parent
- ○ 3 Child
- ○ 4 Other family
- ○ 5 Friend(s)

6.2 Did this person (or any of these people) live with you?

○ 0 No ○ 1 Yes

SECTION TWO: The next set of questions ask about COVID-19 vaccines, exposures, testing and medical care.

7. Have you received a COVID-19 vaccine?

○ 1 Yes ○ 0 No → **Go to Question 7.3.**

↓

7.1 Which vaccine did you get?

○ 1 Johnson and Johnson (Janssen)
○ 2 Pfizer
○ 3 Moderna
○ 4 Astra Zeneca
○ 9 Other or don't know _____

→ **7.2** How many doses have you received?

○ 1 One shot ○ 2 Two shots

7.3 If not, what is the reason you have not been vaccinated? **Mark all that apply.**

○ 1 I am waiting for my appointment
○ 2 I don't know how or where to get a vaccine
○ 3 I have tried but have not been able to get an appointment yet
○ 4 I am waiting for a while before I try to get a vaccine
○ 5 I don't plan to get the vaccine because of a medical condition I have
○ 6 I don't plan to get the vaccine because I am afraid of side effects
○ 7 I don't plan to get the vaccine because I don't trust these vaccines
○ 8 I don't plan to get the vaccine because I'm not worried about getting COVID-19
○ 9 Other, specify: _____

8. To your knowledge, have you EVER been exposed to another person who has been diagnosed with, or suspected of having, COVID-19 infection?

○ 1 Yes, someone living with me
○ 2 Yes, someone outside of my household with whom I have interacted with face-to-face
○ 3 No, not that I know of

9. Since the date on the front of this form, have you been tested for COVID-19?

○ 1 Yes
○ 0 No
○ 9 Unsure
→ **Go to Question 10.**

↓

9.1 What kind of test(s) did you have? **Mark all that apply.**

○ 1 Nasal swab, throat swab, or saliva test (testing for presence of the virus)
○ 2 Blood test (testing for antibodies/immune response)

9.2 How many times have you been tested?

○ 1 1 time ○ 2 2 times ○ 3 3 or more times ○ 9 Unsure

PLEASE MAKE NO MARKS IN THIS AREA

9.3 Why did you get tested? **Mark all that apply.**

- ○ 1 I had symptoms that could suggest I had COVID-19
- ○ 2 I was exposed to someone who was known to have COVID-19
- ○ 3 I was traveling
- ○ 4 It was part of routine screening (for example, to get medical care or as part of a housing or workplace policy)

9.4 Did any of these tests come back positive for a COVID-19 infection?

- ○ 1 Yes
- ○ 0 No
- ○ 9 Unsure

→ **Go to Question 10.**

9.5 Many different symptoms have been associated with COVID-19. Some may be rather short term, others may come and go, and for some people, some symptoms may last a long time. Did you have any of the following symptoms that you believe were associated with COVID-19? If so, how long did you have those symptoms?

	Did you experience this symptom?		**IF YES,** about how long did you have the symptom?			
	No	Yes	< 2 weeks	2 to < 8 weeks	8 weeks to < 6 months	6 months or more
Fever	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Cough	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Headache	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Chest pain/tightness	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Fast-beating heart, heart pounding (palpitations)	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Muscle Pain	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Joint Pain	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Fatigue	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Shortness of breath/ difficulty breathing	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Loss of smell	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Loss of taste	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Sleep disturbance	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Memory problems	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Confusion or difficulty thinking or concentrating	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Brain fog	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4
Malaise--general feeling of illness, discomfort or uneasiness	○ 0	○ 1	○ 1	○ 2	○ 3	○ 4

10. Were you ever hospitalized for COVID-19?

- ○ 1 Yes
- ○ 0 No
- ○ 9 Unsure

→ **Go to Question 11.**

10.1 How many nights did you stay in the hospital? If you had multiple hospitalizations, please provide the total number of nights.

- ○ 1 1 night
- ○ 2 2-3 nights
- ○ 3 4-6 nights
- ○ 4 7-13 nights
- ○ 5 14 or more nights
- ○ 9 Unsure

10.2 What treatments did you receive? **Mark all that apply.**

- ○ 1 Intravenous fluids
- ○ 2 Oxygen through nose prongs or facial mask, but not requiring a ventilator
- ○ 3 BiPAP—a non-invasive external breathing support that provides intermittent airway pressure
- ○ 4 Invasive ventilation or ventilator (Breathing support through an inserted tube. People are usually asleep for this procedure.)
- ○ 5 ECMO—using a machine that puts oxygen in your blood outside of your body, allowing your heart and lungs to rest (People are asleep for this procedure)
- ○ 6 Kidney dialysis
- ○ 8 Other, specify: _____

10.3 Did you require treatment in an Intensive Care Unit (ICU)?

- ○ 1 Yes
- ○ 0 No → **Go to Question 11.**

10.3.1 How many days?

○ 1 1 ○ 2 2-3 ○ 3 4-6 ○ 4 7 or more ○ 9 Not sure

11. Were you given any of the following medications to treat COVID-19? **Mark all that apply.**

- ○ 1 Remdesivir
- ○ 2 Azithromycin
- ○ 3 Antibody therapy
- ○ 4 Convalescent plasma
- ○ 5 Hydroxychloroquine or chloroquine
- ○ 6 Dexamethasone or other corticosteroids
- ○ 7 Immunosuppressive or biologic agents such as IL-6 or TNF blockers
- ○ 8 None of the above
- ○ 9 Don't know

SECTION THREE: In this section we ask about your current access to usual health care, and the impact of the COVID-19 pandemic on your health care.

12. From the date on the front of this form until now, did you have any health care appointments scheduled?

○ 1 Yes ○ 0 No ○ 9 Unsure → **Go to Question 13.**

↓

12.1 Other than appointments to get a COVID-19 vaccination, how did you get your health care since the date on the front of this form? **Mark all that apply.**

○ 1 I had at least one virtual clinic visit by telephone or video
○ 2 I had at least one in-person clinic or office visit
○ 3 I was evaluated at an emergency room or hospital
○ 4 I was hospitalized
○ 5 None of the above--I did NOT seek care from any healthcare provider or go to the emergency room or hospital

13. Have you had a mammogram during the pandemic?

○ 1 Yes
○ 2 No, I chose not to get one because of the COVID-19 pandemic
○ 3 No, I was not due for a mammogram or did not get one for other reasons

14. Have you been treated for cancer during the pandemic?

○ 1 Yes ○ 0 No → **Go to Question 15.**

↓

14.1 If yes, were you scheduled to have any of the following cancer treatments or care during the pandemic?

Type of care	Were you supposed to receive this care during the pandemic?		**IF YES,** did you experience any delays or disruption in getting this care?	
	No	Yes	No	Yes
Surgery	○ 0	○ 1	○ 0	○ 1
Chemotherapy	○ 0	○ 1	○ 0	○ 1
Radiation Therapy	○ 0	○ 1	○ 0	○ 1
Immunotherapy	○ 0	○ 1	○ 0	○ 1
Monitoring (for example, X-rays, MRI, CT scans)	○ 0	○ 1	○ 0	○ 1
Other therapy requiring infusion	○ 0	○ 1	○ 0	○ 1

PLEASE MAKE NO MARKS IN THIS AREA

15. In general, how much difficulty have you had getting routine medical care since the date on the front of this form?

○ 1 None ○ 2 Some ○ 3 Much ○ 4 Unable or very difficult

16. Since the date on the front of this form, have you had any of the following types of care? **Mark all that apply.**

○ 1 Regular medical check-up or routine physical exam
○ 2 Dental appointment
○ 3 Eye exam or appointment with an eye doctor
○ 4 Other routine care
○ 5 None of the above

17. Have you decided not to go to the doctor or hospital when you normally would have gone, to avoid the potential of being exposed to COVID-19?

○ 1 Yes ○ 0 No

SECTION FOUR: In this section, we ask about the impact of the COVID-19 pandemic on your health and general well-being and the changes in your life related to the pandemic.

18. In general, how concerned are you about the COVID-19 pandemic?

○ 1 Not at all concerned ○ 2 Somewhat concerned ○ 3 Very concerned

19. Is the COVID-19 pandemic causing you concerns about any of the following? **Mark all that apply.**

○ 1 My risk of getting a COVID-19 infection
○ 2 The risk of family members or friends getting a COVID-19 infection
○ 3 Getting the health care that I need
○ 4 Getting adequate food
○ 5 Getting enough exercise/physical activity
○ 6 Getting the sleep/rest I need
○ 7 Having adequate housing
○ 8 Having enough money to cover my needs
○ 9 My personal safety
○ 10 The health and safety of my family and friends
○ 11 My financial security
○ 12 The financial security of my family
○ 13 My ability to be with friends and family
○ 14 The nation and the economy more generally
○ 15 None of the above

How often would the following statements apply to you in the **past 7 days**?

	Never	Rarely	Sometimes	Often	Always
20. I felt fearful	○ 1	○ 2	○ 3	○ 4	○ 5
21. I found it hard to focus on anything other than my anxiety	○ 1	○ 2	○ 3	○ 4	○ 5
22. My worries overwhelmed me	○ 1	○ 2	○ 3	○ 4	○ 5
23. I felt uneasy	○ 1	○ 2	○ 3	○ 4	○ 5

In the **past 4 weeks** how often have you felt…	Never	Almost never	Sometimes	Fairly often	Very often
24. That you were unable to control the important things in your life?	○ 1	○ 2	○ 3	○ 4	○ 5
25. Confident about your ability to handle your personal problems?	○ 1	○ 2	○ 3	○ 4	○ 5
26. That things were going your way?	○ 1	○ 2	○ 3	○ 4	○ 5
27. That difficulties were piling up so high that you could not overcome them?	○ 1	○ 2	○ 3	○ 4	○ 5

28. What steps are you currently taking to reduce your risk of being infected by COVID-19? **Mark all that apply.**

- ○ 1 Maintaining a physical distance from people outside my household
- ○ 2 Wearing a face mask when I am with people outside of my household
- ○ 3 Avoiding in-person social or religious activities
- ○ 4 Avoiding or limiting in-person shopping
- ○ 5 Staying home
- ○ 6 None of the above

29. How often do you communicate with others who live outside your home in person, by telephone, email or other methods?

- ○ 1 Every day
- ○ 2 Several times per week
- ○ 3 1-2 times per week
- ○ 4 Once per week
- ○ 5 Rarely or never

30. Over the past month, how would you describe your level of physical activity or exercise, compared to your average physical activity level before the COVID-19 pandemic began?

- ○ 1 Much less
- ○ 2 Somewhat less
- ○ 3 About the same
- ○ 4 Somewhat more
- ○ 5 Much more

31. What is your current weight? _____

32. Have you lost more than 10 pounds in the last 2 years without trying? ○ 0 No ○ 1 Yes

33. Have you gained more than 10 pounds in the last 2 years?

○ 0 No ○ 1 Yes → Were you trying to gain weight? ○ 0 No ○ 1 Yes

34. Thank you for completing this questionnaire. We know this is a challenging time and we appreciate your willingness to continue to help us understand the impact of COVID-19. If there are other aspects that you would like to share, please describe here:

_____

_____

PLEASE MAKE NO MARKS IN THIS AREA

U.S. GOVERNMENT PRINTING OFFICE:2021–576-700/40124 305449-1