Harvard PGP COVID-19 Health Assessment [Ongoing]

Dear PGP Participants,

Below is a health status survey for you to fill out designed to help gain more information about our participants in relation to COVID-19. This is an ongoing survey which you can fill out as frequently as you wish. We suggest you fill it out at a minimum once a week and whenever you have a health status change.

NOTE: As with all PGP phenotype (trait) and medical history surveys, your answers to these questions should be considered public and will be connected to your public PGP profile. Link to the current PGP consent: https://my.pgp-hms.org/static/PGP_Consent_2017-04-21_online.pdf

Thank you,
Harvard PGP Staff

1. Please do not change. This field is auto-populated by the PGP and identifies which participant you are.

2. Are you currently ill with a cold or flu-like illness?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Unknown
- ◯ Prefer not to answer

Symptom List

Persistent high fever of 38°C (100.4°F) or higher, lasting for a day or more
Feeling cold, chills or shivers
Headache
Aches all over the body
Cough
Rapid breathing
Shortness of breath
Wheezing or chest tightness
Persistent pain or pressure in the chest
Bluish lips or face
Dizziness
Confusion or inability to arouse
Running nose
Sore throat
Nausea
Vomiting
Abdominal pain
Diarrhea
Pink eye (conjunctivitis)
Loss of sense of smell
Loss of sense of taste

Note: Please consult your primary care physician or medical provider for any symptoms that are severe or concerning. To learn more about the symptoms of COVID-19, please see https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

3. Currently are you experiencing ANY of the above list of symptoms?

If you answer "Yes" or "Unknown", you will be redirected to a question to specify which symptoms you have experienced and/or are uncertain about.

Mark only one oval.

- ◯ Yes
- ◯ No *Skip to question 5*
- ◯ Unknown
- ◯ Prefer not to answer *Skip to question 5*

4. Indicate which of the following symptoms you are currently experiencing.

Note: Please consult your primary care physician or medical provider for any symptoms that are severe or concerning. To learn more about the symptoms of COVID-19, please see https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Mark only one oval per row.

	Yes	No	Unknown	Prefer not to say
Persistent high fever of 38°C (100.4°F) or higher, lasting for a day or more	◯	◯	◯	◯
Feeling cold, chills or shivers	◯	◯	◯	◯
Headache	◯	◯	◯	◯
Aches all over the body	◯	◯	◯	◯
Cough	◯	◯	◯	◯
Rapid breathing	◯	◯	◯	◯
Shortness of breath	◯	◯	◯	◯
Wheezing or chest tightness	◯	◯	◯	◯
Persistent pain or pressure in the chest	◯	◯	◯	◯
Bluish lips or face	◯	◯	◯	◯
Dizziness	◯	◯	◯	◯
Confusion or inability to arouse	◯	◯	◯	◯
Running nose	◯	◯	◯	◯
Sore throat	◯	◯	◯	◯
Nausea	◯	◯	◯	◯
Vomiting	◯	◯	◯	◯
Abdominal Pain	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯
Pink eye (conjunctivitis)	◯	◯	◯	◯
Loss of sense of smell	◯	◯	◯	◯
Loss of sense of taste	◯	◯	◯	◯

Symptom List

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Feeling cold, chills or shivers
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Note: Please consult your primary care physician or medical provider for any symptoms that are severe or concerning. To learn more about the symptoms of COVID-19, please see https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

5. In the past two weeks, have you experienced ANY of the above list of symptoms?

If you answer "Yes" or "Unknown", you will be redirected to a question to specify which symptoms you have experienced and/or are uncertain about.

Mark only one oval.

- ◯ Yes
- ◯ No *Skip to question 7*
- ◯ Unknown
- ◯ Prefer not to answer *Skip to question 7*

6. In the past 2 weeks, which symptoms have you experienced.

Note: Please consult your primary care physician or medical provider for any symptoms that are severe or concerning. To learn more about the symptoms of COVID-19, please see https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Mark only one oval per row.

	Yes	No	Unknown	Prefer not to say
Persistent high fever of 38°C (100.4°F) or higher, lasting for a day or more				
Feeling cold, chills or shivers				
Headache				
Aches all over the body				
Cough				
Rapid breathing				
Shortness of breath				
Wheezing or chest tightness				
Persistent pain or pressure in the chest				
Bluish lips or face				
Dizziness				
Confusion or inability to arouse				
Running nose				
Sore throat				
Nausea				
Vomiting				
Abdominal pain				
Diarrhea				
Pink eye (conjunctivitis)				
Loss of sense of smell				
Loss of sense of taste				

7. Are you regularly taking any of the following medications? Please choose all those that apply.

Note: If you have concerns about the medications you are taking, please consult your health care provider before making any changes to your medical regimen.

Check all that apply.

- [ ] Ibuprofen (eg. Advil, Midol, Motrin, Motrin IB, Motrin Migraine Pain, Proprinal)
- [ ] Rosiglitazone (eg. Avandia)
- [ ] Pioglitazone (eg. Actos)
- [ ] Azilsartan (e.g.Edarbi)
- [ ] Candesartan (e.g. Atacand)
- [ ] Eprosartan (e.g. Teveten)
- [ ] Irbesartan (e.g. Avapro)
- [ ] Telmisartan (e.g. Micardis)
- [ ] Valsartan (e.g, Diovan, Prexxartan)
- [ ] losartan (e.g. Cozaar)
- [ ] Olmesartan (e.g. Benicar)
- [ ] Sacubitril/Valsartan (e.g. Entresto, Azmarda, Neprivas)
- [ ] Nebivolol/Valsartan (e.g. Byvalson)
- [ ] None of these medications
- [ ] Do not know
- [ ] Prefer not to answer

Other: [ ] _____

8. Have you been tested for coronavirus (COVID-19) by a medical doctor or other official testing service?

Note: If you are concerned that you or a family member may be infected with COVID-19, please contact your primary care physician or medical provider. To learn more about the symptoms of COVID-19, please see https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Mark only one oval.

- ◯ Yes, and the test was positive for coronavirus (COVID-19)
- ◯ Yes, and the test was negative for coronavirus (COVID-19)
- ◯ Yes, but still waiting for test results to be returned
- ◯ No, I tried to get tested but could not get a test
- ◯ No, I have not tried to get tested
- ◯ Prefer not to answer

9. In the past 4 weeks, have you been in close contact with a person who has tested positive for coronavirus (COVID-19)?

Mark only one oval.

- ◯ Yes
- ◯ No *Skip to question 11*
- ◯ Prefer not to answer *Skip to question 11*
- ◯ Other: _____

10. How long ago was your contact with a person who has tested positive for coronavirus (COVID-19)?

Mark only one oval.

- ◯ In current contact
- ◯ 2-14 days
- ◯ Over 2 weeks
- ◯ Prefer not to answer
- ◯ Other: _____

11. In the past 4 weeks, have you been in close contact with a person who has symptoms consistent with coronavirus (COVID-19) but has not been tested?

Note: If you are concerned that you or a family member may be infected with COVID-19, please contact your primary care physician or medical provider. To learn more about the symptoms of COVID-19, please see https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Mark only one oval.

- ◯ Yes
- ◯ No *Skip to section 10 (null)*
- ◯ Prefer not to answer *Skip to section 10 (null)*
- ◯ Other: _____

12. How long ago was your contact with a person who has symptoms consistent with coronavirus (COVID-19) but has not been tested?

Mark only one oval.

- ◯ In current contact
- ◯ 2-14 days
- ◯ Over 2 weeks
- ◯ Prefer not to answer
- ◯ Other: _____

Thank you for filling out the Health Assessment Survey.