

Harvard PGP COVID-19 Health Assessment Week 4: 12 April - 18 April 2020

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 the 4th health assessment survey. We will be sending out a new survey weekly for the next few months. As with all PGP phenotype (trait) and medical history surveys, the 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

3. Since Jan 1, 2020, have you been 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>

4. 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 6*
- ☐ Unknown
- ☐ Prefer not to answer *Skip to question 6*

5. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling cold, chills or shivers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aches all over the body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rapid breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheezing or chest tightness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persistent pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bluish lips or face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion or inability to arouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Running nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pink eye (conjunctivitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Loss of sense of smell

☐☐☐☐

Loss of sense of taste

☐☐☐☐

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>

6. 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 8

☐

Unknown

☐

Prefer not to answer

Skip to question 8

7. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling cold, chills or shivers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aches all over the body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rapid breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheezing or chest tightness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persistent pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bluish lips or face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion or inability to arouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Running nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pink eye (conjunctivitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Loss of sense of smell

☐☐☐☐

Loss of sense of taste

☐☐☐☐

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>

8. Since Jan 1, 2020, to the best of your recollection, 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 10

☐

Unknown

☐

Prefer not to answer

Skip to question 10

9. Since Jan 1, 2020, to the best of your recollection 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling cold, chills or shivers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aches all over the body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rapid breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheezing or chest tightness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persistent pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bluish lips or face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion or inability to arouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Running nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Pink eye (conjunctivitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sense of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Note: A recent study in The Lancet ([https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(20\)30116-8/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30116-8/fulltext)) has suggested that patients that are treated with drugs such as ibuprofen and thiazolidinediones may have an increased risk of developing severe COVID-19. This is still under study. For all comprehensive summary about the current research regarding COVID-19 and ACE inhibitors and Angiotensin II Receptor Blockers (ARBs) see: <http://www.nephjc.com/news/covidace2>. 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, Propinal)
- ☐ 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: ☐ _____

11. 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

12. 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 14*
- ☐ Prefer not to answer *Skip to question 14*
- ☐ Other: _____

13. 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: _____

14. 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 12 (null)*
- ☐ Prefer not to answer *Skip to section 12 (null)*
- ☐ Other: _____

15. 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 for Week 4.

This content is neither created nor endorsed by Google.

Google Forms