FINAL COVID19 Daily Survey

As always, your health and safety are our number one priority. If diagnosed with COVID-19, we hope and encourage you to seek the treatment and care that you need and recover quickly. Any information that you provide us today will be useful in understanding the effects of COVID-19 and the culture of living though a pandemic, but please do not let keeping up with these surveys interfere with your care in any way. Feel free to only respond if you are feeling up to it today.

If you are feeling up to it today, please take a few minutes to fill out this form at your earliest possible convenience, while the information is still fresh in your memory.

As a reminder, we have included some additional questions to this final daily survey to collect information on just a few more things before we wrap up. These questions will appear at the end of the typical Full Version of the survey.

Subject ID

_____
(Provided to you in initial email with link to demographic survey)

Today's Date (Click 'Now')

_____

Last Night's Sleep

For questions asking about time, please use military time. For assistance, you may open the attachment or copy and paste this link into a new tab: https://bit.ly/2HG8yuk

What time did you get into bed last night?

_____

What time did you try to fall asleep last night?

_____

How long did it take you to fall asleep last night (in minutes)?

_____

Approximately how many times did you wake up during the night last night?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5 or more times

In total, how long were you up during the night due to these awakenings (in minutes)?

_____

What time did you wake up this morning?

_____

What time did you get out of bed this morning?

_____

How easy was it to fall asleep last night?

- ◯ It was easy
- ◯ It took some time
- ◯ It was difficult

Did you dream last night?

- ◯ Yes
- ◯ No
- ◯ I don't recall

Please describe in as much detail as you'd like the content of your dreams last night.

_____

Did you take a nap yesterday?

- ◯ Yes
- ◯ No

How many minutes was your nap yesterday?

_____

Were the values reported here influenced/assisted by a sleep tracker of any kind (e.g. Fitbit, Apple Watch, etc)?

- ◯ Yes
- ◯ No

Feel free to include any other relevant information about your sleep here, including any disturbances that contributed to you waking up during the night.

_____

Yesterday's Activity

Do you have a step counter?	◯ Yes ◯ No
If yes, please record the number of steps you took yesterday.	_____
Did you leave your house yesterday?	◯ Yes ◯ No
What places did you visit outside of your home yesterday?	_____
Outside of the people that you live with, approximately how many people did you come into face-to-face contact with yesterday?	_____ (Within "social distance" of 6ft or 2 meters)
Did you do anything to socialize virtually or via phone with family or friends?	◯ Yes ◯ No
How much time did you spend socializing virtually or via phone (in minutes)?	_____
Did you exercise for 20 minutes or more yesteday?	◯ No ◯ Yes, in the morning ◯ Yes, in the afternoon ◯ Yes, in the evening
How many alcoholic beverages did you consume yesterday?	_____

Coronavirus Status

Are you in quarantine?

◯ Yes
◯ No

How many days have you been in quarantine?

_____

Are you experiencing a fever?

◯ Yes
◯ No

How severe has your fever been over the last 24 hours?

Mild			Moderate			Severe
◯	◯	◯	◯	◯	◯	◯

What was your last recorded temperature?

_____

Temperature Units

◯ Celsius
◯ Farenheit

Are you experiencing any respiratory symptoms?

◯ Yes
◯ No
(e.g. coughing, difficulty breathing)

If yes, please describe

_____

How severe have your respiratory symptoms been over the last 24 hours?

Mild			Moderate			Severe
◯	◯	◯	◯	◯	◯	◯

Have you been tested for COVID-19 (i.e. coronavirus)?

◯ Yes
◯ No

Have you been diagnosed with COVID-19 (i.e. coronavirus)?

◯ Yes
◯ No

As a reminder, for confidentiality purposes we are not tracking your responses in real time, nor are we using your responses to generate any diagnoses. If experiencing any symptoms, please be sure to follow guidelines of medical professionals and seek appropriate treatment as needed.

CURRENT FEELINGS AND MOOD

For each of the following personal attributes, indicate which description best describes how you currently feel, right now in the moment.

	Very slightly/not at all	A little	Moderately	Quite a bit	Extremely
Interested	○	○	○	○	○
Distressed	○	○	○	○	○
Excited	○	○	○	○	○
Upset	○	○	○	○	○
Strong	○	○	○	○	○
Guilty	○	○	○	○	○
Scared	○	○	○	○	○
Hostile	○	○	○	○	○
Enthusiastic	○	○	○	○	○
Proud	○	○	○	○	○
Irritable	○	○	○	○	○
Alert	○	○	○	○	○
Ashamed	○	○	○	○	○
Inspired	○	○	○	○	○
Nervous	○	○	○	○	○
Determined	○	○	○	○	○
Attentive	○	○	○	○	○
Jittery	○	○	○	○	○
Active	○	○	○	○	○
Afraid	○	○	○	○	○
Sad	○	○	○	○	○
Happy	○	○	○	○	○
Angry	○	○	○	○	○

	Completely isolated						Not isolated at all/ Socially fulfilled
How socially isolated do you feel?	○	○	○	○	○	○	○

	Completely consumed with worry						Not worried at all
How worried are you about your own health?	○	○	○	○	○	○	○
How worried are you about the health of your family and friends?	○	○	○	○	○	○	○

How worried are you about the health of those in your community?	○	○	○	○	○	○	○
How worried are you about COVID-19 as it is related to a national/global public health crisis?	○	○	○	○	○	○	○
How worried are you about your own finances or the impact of COVID-19 on national/global markets?	○	○	○	○	○	○	○

	Completely consumed by stress						Not stressed at all
How stressed do you currently feel overall?	○	○	○	○	○	○	○

In the last several days, how often have you been bothered by any of the following problems?				
	Not at all	Some of the time	More than half the time	Almost all of the time
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep, staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself- or that you are a failure or that you have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the news or watching television	○	○	○	○
Moving or speaking so slowly that other people could have noticed? - or the opposite problem - being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○

Estimations

Instructions: In this section, we would like to collect some information regarding your ability to estimate certain statistics you may have heard about previously. Please do not look up any supporting information to respond to these questions. It is totally fine to completely guess if you are unsure.

Have you been residing in the US for a majority of the last year?	◯ Yes ◯ No
Approximately how many individuals on average are diagnosed with breast cancer in the US annually?	_____
Approximately how many people voted in the 2020 US election?	_____
Approximately how many total COVID-19 cases were confirmed in the US by the end of October 2021?	_____
Approximately how many total COVID-19 cases were confirmed in your STATE by the end of October 2021?	_____
State:	_____ (This should be the state that you estimated for in the previous question)
Approximately how many individuals on average are diagnosed with breast cancer in your country annually?	_____
Approximately how many total COVID-19 cases were confirmed in your country by the end of October 2021?	_____

COVID Impact

Have you ever received a positive test for COVID19?	◯ Yes ◯ No
Have you ever been diagnosed with COVID19 by a doctor without a formal test?	◯ Yes ◯ No
Do you believe you have ever contracted COVID19 at any point, even without a test or formal diagnosis by a doctor?	◯ Yes ◯ No
How would you rate the severity of the symptoms you experienced/are experiencing?	◯ Mild ◯ Moderate ◯ Severe, but recovered at home ◯ Severe and hospitalized ◯ Hospitalized and needed a ventilator or other lifesaving treatment
Approximate date you contracted COVID19 (Format: Day/Month/Year)	_____
Additional details of COVID19 diagnosis (including additional dates if contracted more than once)	_____
Have you had long-lasting physical impacts due to your COVID19 diagnosis?	◯ Yes ◯ No ((e.g. "COVID long-hauler"))
Has anyone you have lived with contracted COVID19?	◯ Yes ◯ No
Was this confirmed by a test or medical diagnosis?	◯ Yes ◯ No
Has a loved one (family or friend) contracted COVID19?	◯ Yes ◯ No
Was this confirmed by a test or medical diagnosis?	◯ Yes ◯ No
Has a loved one perished due to COVID19?	◯ Yes ◯ No
Has anyone you know personally perished due to COVID19?	◯ Yes ◯ No

1 = Entirely Negative	2	3	4 = Net Neutral	5	6	7 = Entirely Positive

My experience during the COVID19 pandemic has been...	○	○	○	○	○	○	○

Vaccination Information

Have you received any doses of COVID-19 vaccine?	◯ Yes ◯ No
What was the date of your first vaccine dose?	_____ (Format: Month/Day/Year)
Which vaccine did you receive?	_____ (e.g. Pfizer, Moderna, Johnson & Johnson, AstraZeneca)
How many doses of vaccine have you received to date?	◯ 0 ◯ 1 ◯ 2 ◯ 3
Did you have any side effects to any doses of your original vaccination (not including any booster shots)?	◯ No ◯ Yes, mild side effects ◯ Yes, moderate side effects ◯ Yes, severe side effects
Have you received a booster dose of the COVID-19 vaccination?	◯ Yes ◯ No
What was the date of your booster dose?	_____ (Format: Month/Day/Year)
Which vaccine did you receive for your booster?	_____ (e.g. Pfizer, Moderna, Johnson & Johnson, AstraZeneca)
Did you have any side effects to your booster dose of the COVID-19 vaccination?	◯ No ◯ Yes, mild side effects ◯ Yes, moderate side effects ◯ Yes, severe side effects
Do you plan to receive a COVID-19 booster dose when the opportunity arrives?	◯ Yes ◯ No
Do you plan to receive a COVID-19 vaccination when the opportunity arrives?	◯ Yes ◯ No

Final Question

OPTIONAL: This is the FINAL planned assessment question for the study! Please let us know anything else you feel like sharing. Responses can include additional details regarding your experiences during COVID-19 or with your experience as being a participant in this study.

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