

Blood, Urine, and Mouthwash Data Collection Form

[SrvBio_MODULEINTRO_v1r0] Thank you for being part of Connect and for donating your samples. We have some questions about you and your health history. This information will help us better understand your health status, and how it is related to the samples that you donated. If you are not sure of an answer, please make your best guess.

1. [SrvBio_SEX_v1r0] Later questions in this survey will ask about your reproductive health, including your menstrual cycle (if you are menstruating) and your contraceptive use. We want to ask questions that make sense for you. What was your biological sex assigned at birth?
 - 0 Female
 - 1 Male
 - 2 Intersex or other

2. [SrvBio_SYMPTDAY_v1r0] Did you have any of the following symptoms in the 24 hours before you donated your samples? Select all that apply.
 - 0 [SrvBio_COUGHDAY_v1r0] Cough
 - 1 [SrvBio_DIARRDAY_v1r0] Diarrhea
 - 2 [SrvBio_NOSEDAY_v1r0] Stuffy nose (also known as nasal congestion)
 - 3 [SrvBio_VOMITDAY_v1r0] Feeling sick to your stomach or throwing up
 - 4 [SrvBio_FEVERDAY_v1r0] Fever
 - 88 [SrvBio_NOSYMPTDAY_v1r0] No, I had none of these symptoms

3. [SrvBio_EATDRINKBEFORE_v1r0] When did you last eat or drink anything other than water before donating your samples?
 - 0 The same day
 - 1 The day before
 - 2 More than a day before → GO TO SrvBio_SLEEPTIME_v1r0

4. [SrvBio_EATDRINKTIME_v1r0] At about what time did you last eat or drink anything other than water before donating your samples? Select your answer from the drop-down list below. If you are using a phone or tablet, please tap the gray box to enter your response.

HH:MM AM/PM

5. [SrvBio_SLEEPTIME_v1r0] What time did you go to sleep on the night before donating your samples? Select your answer from the drop-down list below. If you are using a phone or tablet, please tap the gray box to enter your response.

HH:MM AM/PM

6. [SrvBio_WAKETIME_v1r0] What time did you wake up on the day that you donated your samples? Select your answer from the drop-down list below. If you are using a phone or tablet, please tap the gray box to enter your response.

HH:MM AM/PM

[SrvBIU_MED_v1r0] **Medications**

7. [GRID_SrvBLU_MED1_V1R0] Have you taken any of these medications in the past month? If so, please share the last time you took each type of medication before donating your samples. If you are not sure of an answer, please make your best guess.

<i>[Radio button grid, select one each row]</i>	0 No	1 Yes, in the past day	2 Yes, in the past two days	3 Yes, in the past week	4 Yes, in the past month
[SrvBIU_TYLENOL_v1r0] Tylenol®					
[SrvBIU_NSAIDS_v1r0] NSAIDs [such as aspirin, Advil®, Aleve®]					
[SrvBIU_ACID_v1r0] Medications to lower stomach acid [such as Prilosec®, Prevacid®, Protonix®, Aciphex®, Omeprazole, Nexium®, Tagamet®, Zantac®]					

**[DISPLAY SrvBIU_REPROINTRO_v1r0 IF (SrvBIU_SEX_v1r0= 0),
ELSE, GO TO SrvBIU_COVIDINTRO_v1r0]**

[SrvBIU_REPROINTRO_v1r0] **Reproductive Health**

The following questions ask about your menstrual periods, if you are pregnant, and contraceptive use. Your answers will help us understand where your body was in your menstrual cycle when you donated your samples. You may have answered some questions like these on another survey, but the questions below ask about your status on the day that you donated your samples.

8. [SrvBIU_MENSTPRD_v1r0] Have you had a menstrual period in the last **12 months**?

[this question requires a response]

0 No → **GO TO SrvBIU_PREGNANT_v1r0**
1 Yes

9. [SrvBIU_MENST60_v1r0] Have you had a menstrual period in the last **60 days**?

[this question requires a response]

0 No → **GO TO SrvBIU_PREGNANT_v1r0**
1 Yes

10. [SrvBIU_MENSTART_v1r0] When was the start date of your most recent menstrual period (the first day on which you saw menstrual blood)? If you are not sure or do not remember, please make your best guess.

[this question requires a response]

MM/DD/YYYY

11. [SrvBIU_PREGNANT_v1r0] Are you pregnant now?

0 No
1 Yes → **GO TO SrvBIU_BRSTFD_v1r0**

12. [SrvBIU_PREG3MON_v1r0] Have you been pregnant in the last **three months**?

- 0 No
- 1 Yes

13. [SrvBIU_BRSTFD_v1r0] Are you breastfeeding now?

- 0 No
- 1 Yes → **GO TO SrvBIU_CONTRACEPT_v1r0**

14. [SrvBIU_BRSTFD3MON_v1r0] Did you breastfeed in the last **three months**?

- 0 No
- 1 Yes

**[DISPLAY SrvBIU_CONTRACEPT_v1r0 IF (SrvBIU_PREGNANT_v1r0= 0),
ELSE, GO TO SrvBIU_COVIDINTRO_v1r0]**

15. [SrvBIU_CONTRACEPT_v1r0] Within the **last month**, have you used hormonal contraceptives? These types of contraceptives include oral contraceptives (“the pill”), injections, implants, skin patches, vaginal rings, and hormonal intrauterine devices (IUDs).

- 0 No
- 1 Yes

16. [SrvBIU_HORMONE_v1r0] Within the **last month**, have you used prescription hormone therapy to relieve common symptoms of perimenopause and menopause (for example, hot flashes and vaginal dryness), or to reduce bone loss due to lowering levels of estrogen and progesterone?

- 0 No
- 1 Yes

[SrvBIU_COVIDINTRO_v1r0] **COVID-19**

The COVID-19 pandemic has been going on since 2020 in the United States. We have some questions about whether you had COVID-19 and any symptoms, your experience during the pandemic, and if you have been vaccinated.

17. [SrvBIU_COV1_v1r0] Have you ever had COVID-19?

- 1 Yes
- 0 No → **GO TO SrvBIU_COV23_v1r0**
- 77 Unsure → **GO TO SrvBIU_COV23_v1r0**

NO RESPONSE → GO TO SrvBIU_COV23_v1r0

18. [SrvBIU_COV2_v1r0] How many times have you had COVID-19?

[_ _] Times

NO RESPONSE → GO TO COV3 AND SET LOOP TO 1 ITERATION

[Fill “first”, “2nd”, “3rd”, etc. according to how many times [SrvBIU_COV3_v1r0] is displayed to the respondent]

19. [SrvBIU_COV3_v1r0] When was the [first/2nd/3rd/etc.] time that you had COVID-19? If you are not sure, please make your best guess.

Month:_____ [SrvBIU_COV3_MONTH_v1r0] Year_____ [SrvBIU_COV3_YEAR_v1r0]

[Soft edit- cannot be before 2020 or past current year, drop down with month and year if possible]

20. [SrvBIU_COV4_v1r0] The [first/2nd/3rd/etc.] time you had COVID-19, did you test **positive**?

1 Yes → **GO TO SrvBIU_COV6_v1r0**

0 No → **GO TO SrvBIU_COV5_v1r0**

77 Unsure → **GO TO SrvBIU_COV5_v1r0**

NO RESPONSE → GO TO SrvBIU_COV5_v1r0

**[DISPLAY SrvBIU_COV5_v1r0 IF (SrvBIU_COV4_v1r0= 0, 77)
ELSE, GO TO SrvBIU_COV6_v1r0]**

21. [SrvBIU_COV5_v1r0] The [first/2nd/3rd/etc.] time you had COVID-19, did a healthcare provider ever tell you they thought you had COVID-19?

0 No

1 Yes

22. [SrvBIU_COV6_v1r0] The [first/2nd/3rd/etc.] time you had COVID-19, did you have any symptoms?

0 No → **GO TO SrvBIU_COVSUMMARY_v1r0**

1 Yes

23. [SrvBIU_COV7_v1r0] When you were experiencing your worst COVID-19 symptoms, the [first/2nd/3rd/etc.] time you had COVID-19, did they interfere with or stop you from doing your daily activities?

0 Not at all

1 A little bit

2 Somewhat

3 Quite a bit

4 Very much

24. [SrvBIU_COV8_v1r0] Did you have any of the following symptoms, the [first/2nd/3rd/etc.] time you had COVID-19? Select all that apply.

0 Fever [SrvBIU_COV8A_v1r0]

1 Body chills (feeling cold, shivering) [SrvBIU_COV8B_v1r0]

2 Body or muscle aches [SrvBIU_COV8C_v1r0]

3 Weakness or fatigue (tiredness) [SrvBIU_COV8D_v1r0]

4 Confusion [SrvBIU_COV8E_v1r0]

5 Trouble sleeping [SrvBIU_COV8F_v1r0]

6 New loss of taste or smell [SrvBIU_COV8G_v1r0]

7 Stuffy nose (nasal congestion) [SrvBIU_COV8H_v1r0]

8 Sore throat [SrvBIU_COV8I_v1r0]

9 Cough [SrvBIU_COV8J_v1r0]

- 10 Shortness of breath (trouble breathing) [SrvBIU_COV8K_v1r0]
- 11 Chest tightness [SrvBIU_COV8L_v1r0]
- 12 Stomach pain [SrvBIU_COV8M_v1r0]
- 13 Diarrhea or watery stool (poop) [SrvBIU_COV8N_v1r0]
- 14 Nausea (being sick to your stomach) [SrvBIU_COV8O_v1r0]
- 15 Vomiting (throwing up) [SrvBIU_COV8P_v1r0]
- 16 Rashes or other skin changes [SrvBIU_COV8Q_v1r0]
- 17 Conjunctivitis (pink eye) [SrvBIU_COV8R_v1r0]
- 55 Other [Free text box] [SrvBIU_COV8S_v1r0] [SrvBIU_COV8S_OTH_v1r0]

25. [SrvBIU_COV9_v1r0] During the [first/2nd/3rd/etc.] time you had COVID-19, did you have septic shock (a condition with symptoms like difficulty breathing, chills, peeing less, and confusion) as a complication of COVID-19?

- 1 Yes
- 0 No
- 77 Unsure

26. [SrvBIU_COV10_v1r0] During the [first/2nd/3rd/etc.] time you had COVID-19, were you diagnosed with pneumonia (a lung or respiratory infection) as a complication of COVID-19?

- 1 Yes
- 0 No
- 77 Unsure

27. [SrvBIU_COV11_v1r0] During the [first/2nd/3rd/etc.] time you had COVID-19, were you diagnosed with blood clots as a complication of COVID-19?

- 1 Yes
- 0 No
- 77 Unsure

28. [SrvBIU_COV12_v1r0] During the [first/2nd/3rd/etc.] time you had COVID-19, did you stay in a hospital overnight for any symptoms or illness related to COVID-19?

- 1 Yes
- 0 No → GO TO SrvBIU_COVSUMMARY_v1r0
- 77 Unsure → GO TO SrvBIU_COVSUMMARY_v1r0

NO RESPONSE → GO TO SrvBIU_COVSUMMARY_v1r0

30. [SrvBIU_COV13_v1r0] How many nights did you stay in the hospital when you had COVID-19 for the [first/2nd/3rd/etc.] time you had COVID-19? If you had multiple overnight hospital stays, please add up all of the nights from each of your stays.

_____ nights

31. [SrvBIU_COV14A_v1r0] While you were in the hospital the [first/2nd/3rd/etc.] time you had COVID-19, did you ever have **oxygen (by mask or nose)**? If you are not sure, please make your best guess.

- 1 Yes → GO TO SrvBIU_COV14B_v1r0

0 No → GO TO SrvBIU_COV15A_v1r0
77 Don't know → GO TO SrvBIU_COV15A_v1r0

NO RESPONSE → GO TO SrvBIU_COV15A_v1r0

[DISPLAY SrvBIU_COV14B_v1r0 IF SrvBIU_COV14A_v1r0= 1
ELSE, GO TO SrvBIU_COV15A_v1r0]

32. [SrvBIU_COV14B_v1r0] How many days were you treated with **oxygen (by mask or nose)** when you had COVID-19 for the [first/2nd/3rd/etc.] time?
__ Days

33. [SrvBIU_COV15A_v1r0] While you were in the hospital the [first/2nd/3rd/etc.] time you had COVID-19, did you ever have a **breathing tube or ventilator**? If you are not sure, please make your best guess.

1 Yes → GO TO SrvBIU_COV15B_v1r0
0 No → GO TO SrvBIU_COV16A_v1r0
77 Don't know → GO TO SrvBIU_COV16A_v1r0

NO RESPONSE → GO TO SrvBIU_COV16A_v1r0

[DISPLAY SrvBIU_COV15B_v1r0 IF SrvBIU_COV15A_v1r0= 1
ELSE, GO TO SrvBIU_COV16A_v1r0]

34. [SrvBIU_COV15B_v1r0] How many days were you treated with a **breathing tube or ventilator** when you had COVID-19 for the [first/2nd/3rd/etc.] time?
__ Days

35. [SrvBIU_COV16A_v1r0] While you were in the hospital the [first/2nd/3rd/etc.] time you had COVID-19, were you **treated in an "intensive care unit" or with ICU monitoring**? If you are not sure, please make your best guess.

1 Yes → GO TO SrvBIU_COV16B_v1r0
0 No → GO TO SrvBIU_COV17A_v1r0
77 Don't know → GO TO SrvBIU_COV17A_v1r0

NO RESPONSE → GO TO SrvBIU_COV17A_v1r0

[DISPLAY SrvBIU_COV16B_v1r0 IF SrvBIU_COV16A_v1r0= 1
ELSE, GO TO SrvBIU_COV17A_v1r0]

36. [SrvBIU_COV16B_v1r0] How many days were you **treated in an "intensive care unit" or with ICU monitoring** when you had COVID-19 for the [first/2nd/3rd/etc.] time?
__ Days

37. [SrvBIU_COV17A_v1r0] While you were in the hospital the [first/2nd/3rd/etc.] time you had COVID-19, did you **receive dialysis treatment**? If you are not sure, please make your best guess.

1 Yes → GO TO SrvBIU_COV17B_v1r0
0 No → GO TO SrvBIU_COVSUMMARY_v1r0
77 Don't know → GO TO SrvBIU_COVSUMMARY_v1r0

NO RESPONSE → GO TO SrvBIU_COVSUMMARY_v1r0

**[DISPLAY SrvBIU_COV17B_v1r0 IF SrvBIU_COV17A_v1r0= 1
ELSE, GO TO SrvBIU_COVSUMMARY_v1r0]**

38. [SrvBIU_COV17B_v1r0] How many days did you **receive dialysis treatment** when you had COVID-19 for the [first/2nd/3rd/etc.] time?
__ Days

39. [SrvBIU_COVSUMMARY_v1r0] Here is a summary of the information you shared about when you had COVID-19 for the [first/2nd/3rd/4th/etc.] time. If any of the information is incorrect, please select the “Back” button to update your response. If all of the information is correct, please select the “Next” button to move forward.

***DISPLAY IF COV3, COV4, COV6, COV8, COV12 WERE DISPLAYED TO THE RESPONDANT]**

Date: [response from [SrvBIU_COV3_v1r0]]*

Positive Test: [response from [SrvBIU_COV4_v1r0]]*

Symptoms present: [response from [SrvBIU_COV6_v1r0]]*

Symptoms: [response(s) from [SrvBIU_COV8C_v1r0]]*

Overnight Hospitalization: [response from [SrvBIU_COV12_v1r0]]*

LOOP OR END DEPENDING ON RESPONSES IN SrvBIU_COV2_v1r0

**[DISPLAY [SrvBIU_COV19_v1r0] IF at least one of the [SrvBIU_COV6_v1r0 = 1],
ELSE, GO TO SrvBIU_COV23_v1r0]**

40. [SrvBIU_COV19_v1r0] Some people who have had COVID-19 reported long-term effects from their illness and from living through the COVID-19 pandemic. Since your COVID-19 diagnosis, have you experienced any of the following symptoms?

41. [GRID_SRVBLU_COV19A_V1R0] Since your COVID-19 diagnosis, have you experienced any of the following symptoms?

<i>[Radio button grid, select one each row]</i>	1 Yes, I have this symptom now.	2 Yes, I have had this in the past, but I do not have it now.	0 No, I never had this symptom.
Loss of taste or smell [SrvBIU_COV19A1_v1r0]			
Appetite changes [SrvBIU_COV19A2_v1r0]			
Feeling generally more tired than you used to feel [SrvBIU_COV19A3_v1r0]			

Trouble remembering things [SrvBIU_COV19A4_v1r0]			
Trouble paying attention [SrvBIU_COV19A5_v1r0]			
Trouble thinking or making decisions [SrvBIU_COV19A6_v1r0]			

42. [GRID_SRVBLU_COV19B_V1R0] Since your COVID-19 diagnosis, have you experienced any of the following symptoms?

<i>[Radio button grid, select one each row]</i>	1 Yes, I have this symptom now.	2 Yes, I have had this in the past, but I do not have it now.	0 No, I never had this symptom.
Shortness of breath [SrvBIU_COV19B1_v1r0]			
Not able to exercise at your usual level [SrvBIU_COV19B2_v1r0]			
Not able to return to work or school [SrvBIU_COV19B3_v1r0]			
Not able to return to your usual activities [SrvBIU_COV19B4_v1r0]			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBIU_COV19B5_v1r0]			

43. [GRID_SRVBLU_COV19C_V1R0] Since your COVID-19 diagnosis, have you experienced any of the following symptoms?

<i>[Radio button grid, select one each row]</i>	1 Yes, I have this symptom now.	2 Yes, I have had this in the past, but I do not have it now.	0 No, I never had this symptom.
Feeling lightheaded or dizzy [SrvBIU_COV19C1_v1r0]			
Periods of racing heart rate [SrvBIU_COV19C2_v1r0]			
Trouble sleeping [SrvBIU_COV19C3_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBIU_COV19C4_v1r0]			
Muscle Aches [SrvBIU_COV19C5_v1r0]			

44. [SrvBIU_COV19C6A_v1r0] Since your COVID-19 diagnosis, have you experienced any other symptoms?

0 No → GO TO SrvBIU_COV20A_v1r0

1 Yes, [Free text box] [SrvBIU_COV19C6ADesc_v1r0]

NO RESPONSE → GO TO SrvBIU_COV20A_v1r0

[DISPLAY SrvBIU_COV19C6B_v1r0 IF SrvBIU_COV19C6A_v1r0= 1

ELSE, GO TO SrvBIU_COV20A_v1r0]

[FILL RESPONSE FROM SrvBIU_COV19C6ADesc_v1r0. IF NO TEXT PROVIDED AT SrvBIU_COV19C6ADesc_v1r0, FILL “THESE OTHER SYMPTOMS”]

45. [SrvBIU_COV19C6B_v1r0] Are you still experiencing [piped response from SrvBIU_COV19C6ADesc_v1r0/these other symptoms]?

1 Yes

0 No

[DISPLAY GRID_SRVBLU_COV20A_V1R0 IF (SrvBIU_COV19A_v1r0=1, 2),

(SrvBIU_COV19B_v1r0=1, 2), (SrvBIU_COV19C_v1r0=1, 2)

ELSE, GO TO SrvBIU_COV25INTRO_v1r0]

46. [GRID_SRVBLU_COV20A_V1R0] How long did you experience the following symptoms?

<i>[Radio button grid, select one each row]</i>	0 Less than 1 month	1 Between 1 and 3 months	2 More than 3 months
Loss of taste or smell [SrvBIU_COV20A1_v1r0]			
Feeling generally more tired than you used to feel [SrvBIU_COV20A2_v1r0]			
Trouble remembering things [SrvBIU_COV20A3_v1r0]			
Trouble paying attention [SrvBIU_COV20A4_v1r0]			
Trouble thinking or making decisions [SrvBIU_COV20A5_v1r0]			
Appetite changes [SrvBIU_COV20A6_v1r0]			
Feeling lightheaded or dizzy [SrvBIU_COV20A7_v1r0]			
Periods of racing heart rate [SrvBIU_COV20A8_v1r0]			
Shortness of breath [SrvBIU_COV20A9_v1r0]			
Not able to exercise at your usual level [SrvBIU_COV20A10_v1r0]			
Not able to return to work or school [SrvBIU_COV20A11_v1r0]			
Not able to return to your usual activities [SrvBIU_COV20A12_v1r0]			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBIU_COV20A13_v1r0]			
Trouble sleeping [SrvBIU_COV20A14_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBIU_COV20A15_v1r0]			

Muscle Aches [SrvBIU_COV20A16_v1r0]			
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[DISPLAY SrvBIU_COV20A17_v1r0 IF (SrvBIU_COV19C6A_v1r0 = 1)

ELSE, GO TO SrvBIU_COV25INTRO_v1r0]

[FILL RESPONSE FROM SrvBIU_COV19C6ADesc_v1r0. IF NO TEXT PROVIDED AT SrvBIU_COV19C6ADesc_v1r0, FILL “THESE OTHER SYMPTOMS”]

47. [SrvBIU_COV20A17_v1r0] How long did you experience [piped response from SrvBIU_COV19C6ADesc_v1r0/ these other symptoms]?

- 0 Less than 1 month
- 1 Between 1 and 3 months
- 2 More than 3 months

48. [SrvBIU_COV21_v1r0] Following your COVID-19 infection in [FILL IN DATES FROM SrvBIU_COV3_v1r0], do you feel that you have fully recovered to your usual state of health?

- 1 Yes
- 2 Yes, mostly
- 0 No → **GO TO SrvBIU_COV25INTRO_v1r0**

49. [SrvBIU_COV22_v1r0] How long did it take you to recover to your usual state of health from the date you first realized you had COVID-19? *NOTE TO PROGRAMMERS: COV22_DAYS MAX = 365.*

_____ months [SrvBIU_COV22_MONTHS_v1r0] _____ days [SrvBIU_COV22_DAYS_v1r0]

→ GO TO SrvBIU_COV25INTRO_v1r0

[DISPLAY SrvBIU_COV23_v1r0 IF ((SrvBIU_COV1_v1r0 =0, 77, non-response) OR

(SrvBIU_COV5_v1r0 =0) OR (SrvBIU_COV6_v1r0= 0))

ELSE, GO TO SrvBIU_COV25INTRO_v1r0]

50. [SrvBIU_COV23_v1r0] Many people have reported challenges related to living during the COVID-19 pandemic that have affected their health. Since the beginning of 2020, have you experienced any of the following symptoms?

51. [GRID_SRVBLU_COV23A_V1R0] Since the beginning of 2020, have you experienced any of the following symptoms?

<i>[Radio button grid, select one each row]</i>	1 Yes, I am experiencing this now.	2 Yes, I experienced this, but I am not experiencing it now.	0 No, I never experienced this.
Loss of taste or smell [SrvBIU_COV23A1_v1r0]			
Appetite changes [SrvBIU_COV23A2_v1r0]			
Feeling generally more tired than you used to feel [SrvBIU_COV23A3_v1r0]			

Trouble remembering things [SrvBIU_COV23A4_v1r0]			
Trouble paying attention [SrvBIU_COV23A5_v1r0]			
Trouble thinking or making decisions [SrvBIU_COV23A6_v1r0]			

52. [GRID_SRVBLU_COV23B_V1R0] Since the beginning of 2020, have you experienced any of the following symptoms?

<i>[Radio button grid, select one each row]</i>	1 Yes, I am experiencing this now.	2 Yes, I experienced this, but I am not experiencing it now.	0 No, I never experienced this.
Feeling lightheaded or dizzy [SrvBIU_COV23B1_v1r0]			
Periods of racing heart rate [SrvBIU_COV23B2_v1r0]			
Shortness of breath [SrvBIU_COV23B3_v1r0]			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBIU_COV23B4_v1r0]			
Trouble sleeping [SrvBIU_COV23B5_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBIU_COV23B6_v1r0]			
Muscle aches [SrvBIU_COV23B7_v1r0]			

53. [SrvBIU_COV23B8A_v1r0] Since the beginning of 2020, have you experienced any other health symptoms?

- 0 No → GO TO SrvBIU_COV24A_v1r0]
1 Yes, [Free text box] [SrvBIU_COV23B8ADesc_v1r0]

NO RESPONSE → GO TO SrvBIU_COV24A_v1r0

**[DISPLAY SrvBIU_COV23B8B_v1r0 IF SrvBIU_COV23B8A_v1r0= 1
ELSE, GO TO SrvBIU_COV24A_v1r0]**

[FILL RESPONSE FROM SrvBIU_COV23B8ADesc_v1r0. IF NO TEXT PROVIDED AT SrvBIU_COV23B8ADesc_v1r0, FILL “THESE OTHER SYMPTOMS”]

54. [SrvBIU_COV23B8B_v1r0] Are you still experiencing [piped response from SrvBIU_COV23B8ADesc_v1r0/these other symptoms]?

- 1 Yes

0 No

**[DISPLAY GRID_SRVBLU_COV24A_V1R0 IF (SrvBIU_COV23A_v1r0= 1, 2),
(SrvBIU_COV23B_v1r0= 1, 2)
ELSE, GO TO SrvBIU_COV25INTRO_v1r0]**

55. [GRID_SRVBLU_COV24A_V1R0] How long did you experience the following symptoms?

<i>[Radio button grid, select one each row]</i>	0 Less than 1 month	1 Between 1 and 3 months	2 More than 3 months
Loss of taste or smell [SrvBIU_COV24A1_v1r0]			
Appetite changes [SrvBIU_COV24A2_v1r0]			
Feeling generally more tired than you used to feel [SrvBIU_COV24A3_v1r0]			
Trouble remembering things [SrvBIU_COV24A4_v1r0]			
Trouble paying attention [SrvBIU_COV24A5_v1r0]			
Trouble thinking or making decisions [SrvBIU_COV24A6_v1r0]			
Feeling lightheaded or dizzy [SrvBIU_COV24A7_v1r0]			
Periods of racing heart rate [SrvBIU_COV24A8_v1r0]			
Shortness of breath [SrvBIU_COV24A9_v1r0]			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBIU_COV24A10_v1r0]			
Trouble sleeping [SrvBIU_COV24A11_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBIU_COV24A12_v1r0]			
Muscle aches [SrvBIU_COV24A13_v1r0]			

**[DISPLAY SrvBIU_COV24A14_v1r0 IF [SrvBIU_COV23B8A_v1r0] = 1
ELSE, GO TO SrvBIU_COV25INTRO_v1r0]
[FILL RESPONSE FROM SrvBIU_COV23B8ADesc_v1r0. IF NO TEXT PROVIDED AT
SrvBIU_COV23B8ADesc_v1r0, FILL “THESE OTHER SYMPTOMS”]**

56. [SrvBIU_COV24A14_v1r0] How long did you experience [piped response from
SrvBIU_COV23B8ADesc_v1r0/these other symptoms]?

- 0 Less than 1 month
- 1 Between 1 and 3 months
- 2 More than 3 months

[SrvBIU_COV25INTRO_v1r0] The following section asks about COVID-19 vaccination and boosters. If you have been vaccinated for COVID-19, it may be helpful to have your COVID-19 vaccine card with you while you complete this section of the survey.

57. [SrvBIU_COV25_v1r0] Did you get vaccinated against COVID-19 ?

- 1 Yes
- 0 No → GO TO SrvMw_ORALHLTH_v1r0
- 77 Don't know → GO TO SrvMw_ORALHLTH_v1r0

NO RESPONSE → GO TO SrvMw_ORALHLTH_v1r0

58. [SrvBIU_COV26_v1r0] How many shots of the COVID-19 vaccine did you get? Please include your initial vaccination and any booster shots.

__ [please have drop down (numeric)]

For each vaccination based on [SrvBIU_COV26_v1r0], [can we include an indicator of which shot?] i.e., with your first shot, with your second shot, with your third shot...

59. [SrvBIU_COV27_v1r0] When did you get vaccinated?

_____ month [SrvBIU_COV27_MONTH_v1r0] _____ year [SrvBIU_COV27_YEAR_v1r0]

[Soft edit- cannot be before 2020 or past current year, drop down with month and year if possible]

60. [SrvBIU_COV28_v1r0] Which COVID-19 vaccine shot did you get?

- 0 Moderna
- 1 Pfizer
- 2 Johnson & Johnson
- 3 AstraZeneca
- 55 Other _____ [SrvBIU_COV28Desc_v1r0]
- 77 Don't know

61. [SrvBIU_COV29_v1r0] Here's a summary of the information you shared about your COVID-19 vaccination. If any of the information is incorrect, please select the "Back" button to update your responses. If all the information is correct, please select the "Next" button to move forward.

Repeat up to total number of vaccinations reported above.

Mouthwash Data Collection

62. [SrvMw_ORALHLTH_v1r0] Overall, how would you rate the health of your teeth and gums?

- 0 Excellent
- 1 Very Good
- 2 Good
- 3 Fair
- 4 Poor
- 77 Don't know

63. [SrvMw_MWBEFORE_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you brush your teeth?

- 1 Yes

0 No

64. [SrvMw_RINSEBEFORE_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you rinse out your mouth?

1 Yes

0 No

65. [SrvMw_GUMBEFORE_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you chew gum?

1 Yes

0 No

66. [SrvMw_TOBACCOBEFORE_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you smoke, vape, or chew any products (including tobacco)?

1 Yes

0 No

67. [SrvMw_HYGIENE_v1r0] Next, we have a few questions about your oral health and routine that will help us better understand your mouthwash (saliva) sample.

In the last **month**, which of these oral hygiene products have you used? Select all that apply.

0 [SrvMw_BRUSH1_v1r0] Toothbrush

1 [SrvMw_FLOSS1_v1r0] Floss

2 [SrvMw_WTRPICK1_v1r0] Water-based flosser or pick/jet

3 [SrvMw_TONGUE1_v1r0] Tongue Cleaner or Scraper

4 [SrvMw_WHITE1_v1r0] Teeth-whiteners (strips, etc.)

5 [SrvMw_MW1_v1r0] Mouthwash

[DISPLAY SrvMw_BRUSH2_v1r0 IF (SrvMw_HYGEINE_v1r0= 0)]

68. [SrvMw_BRUSH2_v1r0] In the last **month**, how often did you use a toothbrush?

44 Never

0 Less than once per week

1 Once or twice per week

2 Three to five times per week

3 Once per day

4 Two or more times per day

[DISPLAY SrvMw_FLOSS2_v1r0 IF (SrvMw_HYGEINE_v1r0= 1)]

69. [SrvMw_FLOSS2_v1r0] In the last **month**, how often did you use floss?

44 Never

0 Less than once per week

- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_WTRPICK2_v1r0 IF (SrvMw_HYGEINE_v1r0= 2)]

70. [SrvMw_WTRPICK2_v1r0] In the last **month**, how often did you use a water-based flosser or pick/jet?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_TONGUE2_v1r0 IF (SrvMw_HYGEINE_v1r0= 3)]

71. [SrvMw_TONGUE2_v1r0] In the last **month**, how often did you use a tongue cleaner or scraper?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_WHITE2_v1r0 IF (SrvMw_HYGEINE_v1r0= 4)]

72. [SrvMw_WHITE2_v1r0] In the last **month**, how often did you use teeth-whiteners (such as whitening strips)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

**[DISPLAY SrvMw_MWUSE_v1r0 IF (SrvMw_HYGEINE_v1r0= 5)
ELSE, GO TO SrvMw_BRUSH2_v1r0]**

73. [SrvMw_MWUSE_v1r0] In the last **month**, which of these mouthwash products have you used?
Select all that apply.

- 0 [SrvMw_MWALC1_v1r0] Alcohol-based mouthwash (such as Scope® or LISTERINE®)
- 1 [SrvMw_MWALCFREE1_v1r0] Alcohol-free mouthwash (such as LISTERINE® Zero)
- 2 [SrvMw_MWCHLOR1_v1r0] Chlorhexidine mouthwash (such as Peridex™, PerioGard®, or Paroex®)
- 3 [SrvMw_MWFLUORIDE1_v1r0] Fluoride mouthwash (such as ACT®)
- 4 [SrvMw_MWPEROX1_v1r0] Peroxide mouthwash (such as Colgate® Peroxyl® Mouth Sore Rinse)
- 5 [SrvMw_MWCETYL1_v1r0] Cetylpyridinium chloride mouthwash (such as Crest® Pro-Health)
- 6 [SrvMw_MWSENSITIVE1_v1r0] Mouthwash for sensitive teeth (such as Sensodyne®)
- 7 [SrvMw_MWDRY1_v1r0] Mouthwash for dry mouth (such as biotène®)

[DISPLAY SrvMw_MWALC_v1r0 IF (SrvMw_MWUSE_v1r0= 0)]

74. [SrvMw_MWALC_v1r0] In the last **month**, how often did you use alcohol-based mouthwash (such as Scope® or LISTERINE®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWALCFREE_v1r0 IF (SrvMw_MWUSE_v1r0= 1)]

75. [SrvMw_MWALCFREE_v1r0] In the last **month**, how often did you use alcohol-free mouthwash (such as LISTERINE® Zero)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWCHLOR_v1r0 IF (SrvMw_MWUSE_v1r0= 2)]

76. [SrvMw_MWCHLOR_v1r0] In the last **month**, how often did you use chlorhexidine mouthwash (such as Peridex™, PerioGard®, or Paroex®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week

- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWFLUORIDE_v1r0 IF (SrvMw_MWUSE_v1r0= 3)]

77. [SrvMw_MWFLUORIDE_v1r0] In the last **month**, how often did you use fluoride mouthwash (such as ACT®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWPEROX_v1r0 IF (SrvMw_MWUSE_v1r0= 4)]

78. [SrvMw_MWPEROX_v1r0] In the last **month**, how often did you use peroxide mouthwash (such as Colgate® Peroxyl® Mouth Sore Rinse)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWCETYL_v1r0 IF (SrvMw_MWUSE_v1r0= 5)]

79. [SrvMw_MWCETYL_v1r0] In the last **month**, how often did you use cetylpyridinium chloride mouthwash (such as Crest® Pro- Health)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWSENSITIVE_v1r0 IF (SrvMw_MWUSE_v1r0= 6)]

80. [SrvMw_MWSENSITIVE_v1r0] In the last **month**, how often did you use mouthwash for sensitive teeth (such as Sensodyne®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMw_MWDRY_v1r0 IF (SrvMw_MWUSE_v1r0= 7)]

81. [SrvMw_MWDRY_v1r0] In the last **month**, how often did you use mouthwash for dry mouth (such as biotène®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

82. [SrvMw_PERMTTHLOST_v1r0] Have you lost any of your permanent adult teeth, not including your wisdom teeth? Select all that apply.

- 1 [SrvMw_PERMTTHLOST1_v1r0] Yes, from accident or injury → **GO TO**
SrvMw_TEETHLOSTAI_v1r0
- 2 [SrvMw_PERMTTHLOST2_v1r0] Yes, from tooth decay or disease → **GO TO**
SrvMw_TEETHLOSTD_v1r0
- 0 [SrvMw_NOPERMTTHLOST_v1r0] No → **GO TO**
SrvMw_DENTURES_v1r0

NO RESPONSE → GO TO SrvMw_DENTURES_v1r0

**[DISPLAY SrvMw_TEETHLOSTAI_v1r0 IF (SrvMw_PERMTTHLOST_v1r0= 1),
ELSE GO TO SrvMw_TEETHLOSTD_v1r0]**

83. [SrvMw_TEETHLOSTAI_v1r0] How many teeth have you lost from accident or injury? Do not include wisdom teeth.

- 0 1
- 1 2 to 4
- 2 5 to 9
- 3 10 or more
- 4 More than one, but not sure how many
- 77 Don't know

[DISPLAY SrvMw_TEETHLOSTD_v1r0 IF (SrvMw_PERMTTHLOST_v1r0= 2),

ELSE GO TO SrvMw_DENTURES_v1r0]

84. [SrvMw_TEETHLOSTD_v1r0] How many teeth have you lost from tooth decay or disease? Do not include wisdom teeth.

- 0 1
- 1 2 to 4
- 2 5 to 9
- 3 10 or more
- 4 More than one, but not sure how many
- 77 Don't know

85. [SrvMw_DENTURES_v1r0] Do you currently use any type of dentures or dental appliance? Please select all you have.

- 1 Dental Bridge [SrvMw_DENTBRIDGE_v1r0]
- 2 Partial denture [SrvMw_PARTDENT_v1r0]
- 3 Full denture [SrvMw_FULLDENT_v1r0]
- 4 Dental Implants [SrvMw_DENTIMP_v1r0]
- 55 Other [SrvMw_DENTOTHER_v1r0]
- 0 No
- 77 Don't know [SrvMw_DENTURES SDK_v1r0]

86. [SrvMw_DENTALCLEAN_v1r0] When did you last have a professional dental cleaning by a dentist or hygienist?

- 0 In the past month
- 1 More than a month ago, but in the past 6 months
- 2 More than 6 months ago, but in the past year
- 3 More than a year ago, but in the past 2 years
- 4 More than 2 years ago
- 77 Don't know

87. [SrvMw_CAVITY_v1r0] Have you ever had a cavity in any of your permanent adult teeth? Please include root caries, which are cavities on the root of the tooth.

- 1 Yes
- 0 No
- 77 Don't know

88. [SrvMw_GUMDISEASE_v1r0] Has a dentist ever told you that you have gum disease (periodontal disease)?

- 1 Yes
- 0 No

77 Don't know

89. [SrvMw_GUMTX_v1r0] Have you ever had treatment for gum disease, such as scaling or root planing, sometimes called “deep cleaning”?

1 Yes

0 No

77 Don't know

90. [SrvMw_ANTIBIO_v1r0] In the **past two months**, have you taken any antibiotic medicine? Common antibiotics include Azithromycin (such as Zithromax®/Z-Paks®), Penicillin (such as Pfizerpen® or Pen-Vee K®), and Amoxicillin (such as Amoxil®) and are generally used to treat infections.

1 Yes → **GO TO SrvMw_ANTIBIOTIME_v1r0**

0 No → **GO TO END**

77 Don't know → **GO TO END**

NO RESPONSE → GO TO END

91. [SrvMw_ANTIBIOTIME_v1r0] When did you last take antibiotic medicine?

0 Within the last 24 hours

1 More than 24 hours ago, but in the past week

2 More than 1 week ago, but in the past 4 weeks

3 More than 4 weeks ago

[Same thank you message as other modules (“Thank you for submitting your survey. If you are using a shared device, please remember to log out of the MyConnect app and any email accounts you have open.”)]