

DATE	TEAM MEMBER	CHANGE
Nov 2020-Jan 2021	Alaina Shreves	Changed title from “Specimen to “Blood and Urine”
Nov 2020-Jan 2021	Alaina Shreves	Add variable names
Nov 2020-Jan 2021	Alaina Shreves	[BioBUQ_SymptDay_v1r0] Changed last option from “No, I had none of these” to “No, I have none of these”
Nov 2020-Jan 2021	Alaina Shreves	Moved [BioBUQ_Med_v1r0] into a grid
Nov 2020-Jan 2021	Alaina Shreves	[BioBUQ_OtherMed_v1r0] added a sentence in question text “Please exclude any hormonal contraceptives or prescription hormone therapy because we will ask about those medications later.”
Nov 2020-Jan 2021	Alaina Shreves	Remove duration questions from [BioBUQ_OtherMed_v1r0], add duration questions after [BioBUQ_OtherMed_v1r0]. Added [BioBUQ_Med1Freq_v1r0], [BioBUQ_Med2Freq_v1r0], [BioBUQ_Med3Freq_v1r0], [BioBUQ_Med4Freq_v1r0].
Nov 2020-Jan 2021	Alaina Shreves	Added [BioBUQ_Sex_v1r0] to ask about biological sex, changed skip pattern for menstrual cycle to pull answer from [BioBUQ_Sex_v1r0] instead of user profile.
Nov 2020-Jan 2021	Alaina Shreves	[BioBUQ_MenstStart_v1r0] removed multiple ‘yes’ options, only include yes and no options
2/12/2021	Alaina Shreves	Updated language for BioBUQ_MenstStart_v1r0 to include statement asking for best guess and elaborating on “this does no apply” option
2/12/2021	Nicole Gerlanc	Added variable names to sub-questions of questions A, BioBUQ_SampleTime_v1r0, and 7, BioBUQ_MenstStart_v1r0, because sub-questions are different format types.
2/12/2021	Alaina Shreves	Change variables names BioBUQ to SrvBIU

		Adding SrvBIU_ModuleIntrovariable name for introduction text
3/15/2021	Deanna DePietro	Reviewed for style and clarity, tracked suggested edits
3/19/2021	Alaina Shreves	Moved sex question to earlier in module
3/25/2021	Alaina Shreves	Cleaned up track changes to make a clean file, resolved comments
4/22/2021	Alaina Shreves	Added variable numbering for programming
4/26/2021	Alaina Shreves	Updated variable numbers (0 = first option)
7/19/2021	Julie Cusack	Update content and added comments based on 7/19 meeting with Mia, Neal & Julie
7/26/2021	Mia Gaudet	Reviewed menstrual cycle questions to improve flow and clarity
7/27/21	Julie Cusack	Changing order and format of symptoms. Copied Blood_Urine_Quex_03252021, applied edits for this clean version named Blood_Urine_Quex_07272021
7/28/21	Julie Cusack	Removed “write-in” questions on additional medications. Changed order of vaccine responses. Added duration questions for pandemic health problems
8/23/21	Julie and Neal	Simplified skip patterns for date
8/30/21	Julie and Neal	Renamed Qx to clinical collection, removed question about donation date/time, removed “sample or” from “when did you donated your sample or samples” questions.

Blood and Urine Data Collection Form

[SrvBIU_ModuleIntro] 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.

[SrvBIU_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

[SrvBIU_SymptDay_v1r0] Did you have any of the following symptoms in the 24 hours before you donated your samples? Select all that apply.

- 0 [SrvBIU_CoughDay_v1r0] Cough
- 1 [SrvBIU_DiarrDay_v1r0] Diarrhea
- 2 [SrvBIU_NoseDay_v1r0] Stuffy nose (also known as nasal congestion)
- 3 [SrvBIU_VomitDay_v1r0] Feeling sick to your stomach or throwing up
- 4 [SrvBIU_FeverDay_v1r0] Fever
- 5 [SrvBIU_NoSymptDay_v1r0] No, I had none of these symptoms

[SrvBIU_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 [Q6]**

[SrvBIU_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.

HH:MM AM/PM

[SrvBIU_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.

HH:MM AM/PM

[SrvBIU_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.

HH:MM AM/PM

Medications

[SrvBIU_Med_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.

[Radio button grid, select one each row]

Pain relievers	0 No	1 Yes, in the last day	2 Yes, in the last two days	3 Yes, in the last week	4 Yes, in the last 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, Acidphex, Omeprazole, Nexium, Tagamet, Zantac]					

[If SrvBIU_Sex_v1r0 = Male OR SrvBIU_Sex_v1r0 = Intersex or Other, GO TO COVIDINTRO]

[DISPLAY SrvBIU_MenstrPrd_v1r0 IF SrvBIU_Sex_v1r0 = Female]

[SrvBIU_ReproIntro_v1r0]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.

[SrvBIU_MenstrPrd_v1r0] Have you had a menstrual period in the last **12 months**?

- 1 Yes
- 0 No GO TO SrvBIU_Pregnant_v1r0

[DISPLAY SrvBIU_MenstrStart_v1r0 IF SrvBIU_MenstrPrd_v1r0 =YES]

[SrvBIU_MenstrStart_v1r0] When was the start date of your most recent period (the first day on which you saw menstrual blood)? If you are not sure or do not remember, please make your best guess.

MM/DD/YYYY

- 0 This does not apply to me

[SrvBIU_Pregnant_v1r0] Are you pregnant now?

- 1 Yes > **GO TO** SrvBIU_Brstfd_v1r0
- 0 No > **GO TO** SrvBIU_Preg3Mon_v1r0

[SrvBIU_Preg3Mon_v1r0] Have you been pregnant in the last **three months**?

- 1 Yes
- 0 No

[SrvBIU_Brstfd_v1r0] Are you breastfeeding now?

- 1 Yes > **GO TO** SrvBIU_Contracept_v1r0
- 0 No > **GO TO** SrvBIU_Brstfd3Mon_v1r0

[SrvBIU_Brstfd3Mon_v1r0] Did you breastfeed in the last **three months**?

- 1 Yes
- 0 No

[DISPLAY SrvBIU_Contracept_v1r0 IF SrvBIU_Pregnant_v1r0 =NO]

[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).

- 1 Yes
- 0 No

[DISPLAY SrvBIU_Hormone_v1r0 IF SrvBIU_Pregnant_v1r0 =NO]

[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?

- 1 Yes
- 0 No

[COVIDINTRO] 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.

[SrvBIU_CovTst_v1r0] Have you ever been tested for the novel coronavirus COVID-19? Please include all types of tests (including nose or throat swabs, spit, blood, PCR, antigen, or antibody tests).

- 1 Yes
- 0 No > GO TO Question SrvBIU_CovRep_v1r0
- 77 Unsure > GO TO Question SrvBIU_CovRep_v1r0

[SrvBIU_CovTstPos_v1r0] Have you ever tested **positive** for COVID-19?

- 1 Yes
- 0 No > GO TO Question SrvBIU_CovRep_v1r0
- 77 Unsure > GO TO Question SrvBIU_CovRep_v1r0

[SrvBIU_CovTstDat_v1r0] When was the **first time** that you tested positive for COVID-19? If you are not sure, please make your best guess.

Month: ____ Year ____

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

[SrvBIU_CovTstTyp_v1r0] The **first time** that you tested positive for COVID-19, what type of test did you have?

- 0 Nose (“nasal”, “nasopharyngeal”) swab
- 1 Throat swab
- 2 Spit (“saliva”) test
- 3 Blood test (either “blood draw,” “tube,” “dried blood spot,” or “finger prick”)
- 55 Other: _____

{NOTE- If test showed you had COVID-19 = YES > GO TO Question SrvBIU_CovSympt_v1r0}

[SrvBIU_CovRep_v1r0] We know that some people may have had COVID-19 without getting a test. Do you think that you may have had COVID-19?

- 0 Yes, definitely
- 1 Yes, I think so
- 2 Maybe
- 3 No > GO TO Question SrvBIU_CovPanSympt_v1r0

[SrvBIU_CovRepDt_v1r0] When do you think you **first** had COVID-19? If you are not sure, please make your best guess.

Month: _____ Year _____

[Soft edit- cannot be before November 2019 or past current year, drop down with month and year if possible]

[SrvBIU_CovRepHlth_v1r0] Did a healthcare provider ever tell you they thought you had COVID-19?

- 1 Yes
- 0 No

[SrvBIU_CovSympt_v1r0] When you had COVID-19, did you have any symptoms?

- 1 Yes
- 0 No > GO TO SrvBIU_CovPanSympt_v1r0

[SrvBIU_CovDlyAct_v1r0] When you were experiencing your worst COVID-19 symptoms, 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

[SrvBIU_CovSympt_v1r0] When you had COVID-19, did you have any of the following symptoms? Please mark yes for any symptom that **started or got worse** when you had COVID-19.

[Radio button grid, select one each row]

Part one

Symptoms	1 Yes	2 No
Fever [SrvBIU_CovFever_v1r0]	<input type="radio"/>	<input type="radio"/>
Body chills (feeling cold, shivering)[SrvBIU_CovChill_v1r0]	<input type="radio"/>	<input type="radio"/>
Body or muscle aches [SrvBIU_CovAche_v1r0]	<input type="radio"/>	<input type="radio"/>
Weakness or fatigue (tiredness) [SrvBIU_CovWeak_v1r0]	<input type="radio"/>	<input type="radio"/>
Confusion [SrvBIU_CovConf_v1r0]	<input type="radio"/>	<input type="radio"/>
Trouble sleeping [SrvBIU_CovTrSlp_v1r0]	<input type="radio"/>	<input type="radio"/>


Part two

Symptoms	1 Yes	2 No
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New loss of taste or smell [SrvBIU_CovTsteSmll_v1r0]	<input type="radio"/>	<input type="radio"/>
Stuffy nose (nasal congestion) [SrvBIU_CovNasal_v1r0]	<input type="radio"/>	<input type="radio"/>
Sore throat [SrvBIU_CovSorThrt_v1r0]	<input type="radio"/>	<input type="radio"/>
Cough [SrvBIU_CovCgh_v1r0]	<input type="radio"/>	<input type="radio"/>
Shortness of breath (trouble breathing) [SrvBIU_CovBrth_v1r0]	<input type="radio"/>	<input type="radio"/>
Chest tightness [SrvBIU_CovTightCh_v1r0]	<input type="radio"/>	<input type="radio"/>

Part three

Symptoms	1 Yes	2 No
Stomach pain [SrvBIU_CovAbPain_v1r0]	<input type="radio"/>	<input type="radio"/>
Diarrhea or watery stool (poop) [SrvBIU_CovDiarr_v1r0]	<input type="radio"/>	<input type="radio"/>
Nausea (being sick to your stomach) [SrvBIU_CovNaus_v1r0]	<input type="radio"/>	<input type="radio"/>
Vomiting (throwing up) [SrvBIU_CovVom_v1r0]	<input type="radio"/>	<input type="radio"/>
Rashes or other skin changes [SrvBIU_CovSkinC_v1r0]	<input type="radio"/>	<input type="radio"/>
Conjunctivitis (pink eye) [SrvBIU_CovConjun_v1r0]	<input type="radio"/>	<input type="radio"/>
Other [Free text box] [SrvBIU_CovSymptOth_v1r0]	<input type="radio"/>	<input type="radio"/>

[SrvBIU_CovSeptic_v1r0] Did you ever have septic shock (a condition with symptoms like difficulty breathing, chills,  less, and confusion) as a complication of COVID-19?

- 1 Yes
- 0 No
- 77 Unsure

[SrvBIU_CovPneum_v1r0] Were you ever diagnosed with pneumonia (a lung or respiratory infection) as a complication of COVID-19?

- 1 Yes
- 0 No
- 77 Unsure

Were you ever diagnosed with blood clots as a complication of COVID-19?

- 1 Yes
- 0 No
- 77 Unsure

[SrvBIU_CovHsp_v1r0] Did you ever stay in a hospital overnight for any symptoms or illness related to COVID-19?

- 1 Yes
- 0 No > GO TO Question SrvBIU_CovLngSympt_v1r0
- 77 Unsure> GO TO Question SrvBIU_CovLngSympt_v1r0

[SrvBIU_CovHspNum_v1r0] How many nights did you stay in the hospital? If you had multiple overnight hospital stays, please add up all of the nights from each of your stays.

_____ nights

[SrvBIU_CovHspTrt_v1r0] While you were in the hospital, did you ever have any of the following treatments? If you are not sure, please make your best guess.

[Radio button grid, select one each row]

Treatment	1 Yes	0 No	77 Do not know
Oxygen (by mask or nose) [SrvBIU_CovHspOxy_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A breathing tube or ventilator [SrvBIU_CovHspVent_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
“Intensive care unit” or ICU monitoring [SrvBIU_CovHspICU_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dialysis [SrvBIU_CovHspDial_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

{NOTE- If all NO or DON'T KNOW or did not answer > GO TO Question

Treatment	#Days needed
Oxygen (by mask or nose) [SrvBIU_CovHspOxyD_v1r0]	_____
A breathing tube or ventilator [SrvBIU_CovHspVentD_v1r0]	_____
“Intensive care unit” or ICU monitoring [SrvBIU_CovHspICUD_v1r0]	_____
Dialysis [SrvBIU_CovHspDialD_v1r0]	_____

[SrvBIU_CovLngSympt_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?

[Radio button grid, select one each row]

Part one

Symptoms	0 Yes, I have this symptom now.	1 Yes, I have had this in the past, but I do not have it now.	2 No, I never had this symptom.
Loss of taste or smell	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite changes[SrvBIU_CovLngApp_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling generally more tired than you used to feel [SrvBIU_CovLngTrd_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering things [SrvBIU_CovLngMem_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble paying attention [SrvBIU_CovLngAttn_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble thinking or making decisions [SrvBIU_CovLngDec_v1r0]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Part two

Symptoms	0 Yes, I have this symptom now.	1 Yes, I have had this in the past, but I do not have it now.	2 No, I never had this symptom.
Shortness of breath			
Not able to exercise at your usual level [SrvBIU_CovLngExer_v1r0]			
Not able to return to work or school [SrvBIU_CovLngWk_v1r0]			
Not able to return to your usual activities [SrvBIU_CovLngAct_v1r0]			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBIU_CovLngPhysAct_v1r0]			

Part three

Symptoms	0 Yes, I have this symptom now.	1 Yes, I have had this in the past, but I do not have it now.	2 No, I never had this symptom.
Feeling lightheaded or dizzy [SrvBIU_CovLngLght_v1r0]			
Periods of racing heart rate [SrvBIU_CovLngRace_v1r0]			
Trouble sleeping [SrvBIU_CovLngSlp_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBIU_CovLngMood_v1r0]			
Muscle Aches			
Other [Free text box] [SrvBIU_CovLngOthr_v1r0]			

[DISPLAY *insert* if *responses from* SrvBIU_CovLngSympt_v1r0=0 or =1. How long did you experience the following symptoms?

Symptom	0 less than 1 month	1 Between 1-3 months	2 over 3 months
Loss of taste or smell			
Feeling generally more tired than you used to feel			
Trouble remembering things			
Trouble paying attention			
Trouble thinking or making decisions			

Appetite changes			
Feeling lightheaded or dizzy			
Periods of racing heart rate			
Shortness of breath			
Not able to exercise at your usual level			
Not able to return to work or school			
Not able to return to your usual activities			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise			
Trouble sleeping			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual)			
Muscle Aches			
Other [Free text box]			

[SrvBIU_CovRecov_v1r0] Following your COVID-19 infection in [FILL IN DATES FROM SrvBIU_CovTstDat_v1r0], do you feel that you have fully recovered to your usual state of health?

- 0 Yes, completely
- 1 Yes, mostly
- 2 No > GO TO Question SrvBIU_CovVax_v1r0

[SrvBIU_CovRecovDt_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?

____ months ____ days

> GO TO Question SrvBIU_CovVax_v1r0

[SrvBIU_CovPanSympt_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 health problems?

[Radio button grid, select one each row]

Part one

Health Problems	0 Yes, I am experiencing this now.	1 Yes, I experienced this, but I am not experiencing it now.	2 No, I never experienced this.
Loss of taste or smell			
Appetite changes [SrvBIU_CovPanApp_v1r0]			
Feeling generally more tired than you used to feel [SrvBIU_CovPanTrd_v1r0]			
Trouble remembering things [SrvBIU_CovPanMem_v1r0]			

Trouble paying attention [SrvBIU_CovPanAttn_v1r0]			
Trouble thinking or making decisions [SrvBIU_CovPanDec_v1r0]			


Part two

Health Problems	0 Yes, I am experiencing this now.	1 Yes, I experienced this, but I am not experiencing it now.	2 No, I never experienced this.
Feeling lightheaded or dizzy [SrvBIU_CovPanLght_v1r0]			
Periods of racing heart rate [SrvBIU_CovPanRace_v1r0]			
Shortness of breath			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise [SrvBIU_CovPanPhysAct_v1r0]			
Trouble sleeping [SrvBIU_CovPanSlp_v1r0]			
Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual) [SrvBIU_CovPanMood_v1r0]			
Muscle aches			
Other [Free text box] [SrvBIU_CovPanOthr_v1r0]			

[DISPLAY *insert* if *responses from* SrvBIU_CovPanSympt_v1r0 =0 or =1. How long did you experience the following symptoms?

Health Problems	0 less than 1 month	1 Between 1-3 months	2 over 3 months
Loss of taste or smell			
Appetite changes			
Feeling generally more tired than you used to feel			
Trouble remembering things			
Trouble paying attention			
Trouble thinking or making decisions			
Feeling lightheaded or dizzy			
Periods of racing heart rate			
Shortness of breath			
Feeling weak, tired and/or sick 24-48 hours after physical activity or exercise			
Trouble sleeping			

Changes in your mood and emotions (such as feeling sad, anxious, or annoyed more than usual)			
Muscle aches			
Other [Free text box]			


[SrvBIU_CovVax_v1r0]  you get a COVID-19 vaccination?

- 0 Yes
- 1 No > GO TO end
- 77 Do not know > GO TO end

[SrvBIU_CovVaxDos_v1r0] How many shots of vaccine did you get?

- 0 One
- 1 Two
- 2 Three
- 3 Other, please specify [please have drop down (numeric)]

For each vaccination based on [SrvBIU_CovVaxDos_v1r0], [can we include an indicator of which shot?] ie for your first shot, for your second shot, for your third shot...


 [SrvBIU_CovVaxDt_v1r0] When were you vaccinated?

____ month ____ year

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

[SrvBIU_CovVaxTyp_v1r0] Which COVID-19 vaccine shot did you get?

- 0 Moderna
- 1 Pfizer
- 2 Johnson & Johnson
- 3 AstraZeneca
- 55 Other _____ [SrvBIU_CovVaxOthr_v1r0]
- 77 Do not know

 Repeat up to total number of vaccinations reported above.

[Same thank you message as other modules]

