Novel Coronavirus (COVID) Illness – Patient Report (NCI-PR)

Today's Date _____ [date]

1. What is your gender? (check all that apply) [gender]

1 Male
2 Female
3 Option to self-describe: _____
999 Prefer not to answer

If 3, then:
Option to self-describe: (open field) [gender_selfdescribe]

2. Do you believe that you have been personally infected with COVID? This includes presumed positive regardless of whether you had testing done. (check one) [infected_covid]

1 Yes
0 No
(if No then jump to final 2 questions about current situation and then end measure)

3. How do you think you caught COVID? (check one) [infected_caught_covid]

1 Person-to-person contact (droplets from cough, sneeze or breath)
2 Contaminated foods or surfaces
3 Both, person-to-person contact and contaminated objects
999 Unsure

If 1 or 3, then:
3.1 What led to person-to-person contact? (check one) [infected_inperson_covid]

1 Infected individual in home
2 Spending time in public spaces
3 While fulfilling my job duties
4 While receiving medical care
5 While helping or supporting others with illness

4. Are you currently COVID positive? (check one) [current_covid_status]

1 Yes
0 No

I. COVID Testing

5. Have you been tested for COVID (antibodies or active illness)? (check one) [test_any]

1 Yes
0 No
999 Unsure

If yes, then:
5.1 Have you had a positive COVID PCR test (throat or nose swab)? (check one) [test_pos_pcr]

1 Yes
0 No

If yes, then:

5.1.2 Number of times you have had a positive COVID PCR test (check one) [test_frequency_pcr)]

0 0
1 1
2 2
3 3
4 4
5 5
6 More than 5

if test_frequency_pcr > 1, then 3.1.3-3.1.5 repeat up to 3 times with "date of first test"; "date of second test"; etc

5.1.3 When did you get your first test? (check one) [test_pcr_date]

1 February 2020
2 March 2020
3 April 2020
4 May 2020
5 June 2020
6 July 2020
7 August 2020
8 September 2020
9 October 2020
10 November 2020
11 December 2020
12 January 2021
13 February 2021
14 March 2021
15 April 2021
16 May 2021
0 None of these

5.1.4 Where did you receive your throat/nose swab COVID test? (check one) [test_pcr_locat]

1 Urgent care
2 Drive-through testing site
3 Pharmacy
4 Outpatient office
5 Hospital or Emergency Department
6 Other_____ [test_pcrlocat_other]

5.1.5 Did you have symptoms when you received your throat/nose swab? (check one) [test_pcr_symp]

1 Yes
0 No

5.2 Have you had a <u>blood</u> test for COVID antibodies? (check one) [test_antib]

1 Yes
0 No

If yes, then:

5.2.1 Have you tested positive for COVID antibodies? (check one) [test_antib_pos]

1 Yes, I have tested positive for antibodies (at least once)
0 No, I completed a blood test, but I was negative for antibodies

5.2.2 Date of most recent test(s) (date field) [test_antib_date]

5.2.3 Where did you receive your blood antibody COVID test(s)? (check one) [test_antib_locat]

1 Urgent care
2 Drive-through testing site
3 Pharmacy
4 Outpatient office
5 Hospital or Emergency Department
6 Other_____ [test_antiblocat_other]

5.2.4 Did you have symptoms when you were tested for antibodies? (check one) [test_antib_symp]

1 Yes
0 No

5.3 Why were you tested? (check one) [test_reason]

1 Pre-existing health condition (self, including pregnacy)
2 Susceptible family member at home
3 I had symptoms
4 Reasons related to my job
5 Curiosity
6 Other_____ [test_reason_other]

If 1, then:

5.3.1 Which pre-existing health conditions apply to you? (check all that apply) [test_reason_health]

1 Pregnancy
2 Immune system health concerns
3 Respiratory health concerns (e.g., asthma, COPD)
4 Cardiac health concerns
5 Cancer
6 Sickle cell disease
7 Diabetes
8 High blood pressure
9 Cystic fibrosis
0 None of these

If 4, then:

5.3.2 Did your employer make testing <u>mandatory</u>? (check one) [test_job_mandatory]

1 Yes
0 No
999 Unsure

If 4, then:

5.3.3 Why was it helpful for your job to be tested? (check one) [test_job_reason]

1 Healthcare worker
2 First responder
3 Essential worker
4 Work with susceptible populations
5 Other

If 5, then:

Please specify other: (open field) [testjobreason_other]

II. COVID Timing, Symptoms and Complications

6. Were you ill with COVID symptoms more than once? (check one) [repeat_illness]

1 Yes
0 No

If identifies as female, then:

7. Did you have COVID while you were pregnant? (check one) [pregnant_any]

1 Yes
0 No

If yes, then:

7.1 Which trimester were you in? (check one) [pregnant_trimester]

1 First
2 Second
3 Third

For remaining questions, refer to experiences during your most significant illness experience [repeat_illness_yes]

8. When did you first become ill with COVID? (drop down) [onset_date]

1, February 2020
2, March 2020
3, April 2020
4, May 2020
5, June 2020
6, July 2020
7, August 2020
8, September 2020
9, October 2020
10, November 2020
11, December 2020
12, January 2021
13, February 2021
14, March 2021
15, April 2021
16, May 2021
0, None of these

9. How long were you ill with COVID-19 (in days) (number) [illness_length]

(not a required response, as illness may not be resolved at time of assessment; later question addresses this)

10. What symptoms did you experience while you were ill with COVID? (check all that apply) [symptoms_all]

1 Fever (>100.4 F/38 C)
2 Chills or Shaking
3 Cough
4 Shortness of Breath/Difficulty Breathing
5 Wheezing
6 Chest Pressure/Chest Pain

7 Sore Throat
8 Runny Nose/Sinus Congestion
9 Sneezing
10 Diarrhea (>=3 loose/looser than normal stools/24 hr. period)
11 Muscle Pain/Body Aches
12 Headache
13 Partial Loss of Smell (Partial Anosmia)
14 Complete Loss of Smell (Anosmia)
15 Partial Loss of Taste (Partial Ageusia)
16 Complete Loss of Taste (Ageusia)
17 Nausea or Vomiting
18 Bluish Lips/Face
19 Confusion or Inability to Arouse
20 Unusual Fatigue/Lethargy
21 Eye Redness with or without Discharge
22 Ear pain
23 Skin rash or Skin ulcers
24 Other
Please specify other: _____ [ncipr_symptoms_all_other_d]
0 None of these apply

If yes, then:

10.1 Was your fever ever greater than 103.0 F/39.4 C? (check one) [ncipr_fever_level]
1 Yes
0 No

If yes, then:

10.2 How long did you experience Fever? (check one) [ncipr_symptoms_all_01_days2]
1 Less than 24 hours
2 24 to 48 hours
3 48 to 72 hours
4 More than 72 hours

If 3 selected, then:

10.3 Please describe your type of cough: (check one) [cough_type]
1 dry
2 wet
3 other

If 3 selected, then:

10.3.1 Please specify other: (open field) [cough_type_other]

11. Which medical complications did you experience? (check all that apply) [symptoms_med_complicat]
1 Pneumonia (Bacterial or Viral)
2 Inadequate Oxygen or Hypoxia
3 Water in the Lungs (Pleural effusion)
4 Collapsed Lung (Pneumothorax)
5 Acute Respiratory Distress Syndrome
6 Sepsis (serious infection that causes your immune system to attack your body)
7 Heart Inflammation (Endocarditis, Myocarditis, Pericarditis)
8 Cardiac Problems (Cardiomyopathy, Cardiac ischemia/arrhythmia, heart failure)

9 Kidney Injury or Failure
10 Liver Dysfunction
11 Bleeding in digestive tract (Gastrointestinal Hemorrhage)
12 Hyperglycemia/ Hypoglycemia (Abnormal Blood Sugar)
13 Stroke / Cerebrovascular accident
14 Seizure
15 Inflammation or infection of the brain or meninges (Meningitis / Encephalitis)
16 Anemia (Lack of red blood cells or hemoglobin)
0 None of these

12. Maximum temperature recorded (Please be sure to indicate temperature scale i.e. ºF or ºC): (number, incl. decimals) [max_temp]

13. Lowest oxygen saturation recorded (if you don't know, please enter 'N/A") (number, incl. decimals) [min_osat]
~~999 Unsure~~

14. What was the most concerning COVID symptom or medical complication that you experienced? (check one) [symptom_worst]
1 Fever
2 Chills or Shaking
3 Cough
4 Difficulty Breathing/Chest Pressure
5 Loss of Taste or Smell
6 Sore Throat
7 Runny Nose/Sinus Congestion
8 Diarrhea
9 Muscle Pain/Body Aches
10 Headache
11 Fatigue
12 Nausea/Vomiting
13 Seizure or Loss of Consciousness
14 No symptoms experienced
15 Other, specify

If 15, then:
14.1: Please specify other: (textfield) [ncipr_symptom_worst_other]

15. Did you experience the following? (check all that apply) [symptoms_events]
1 Stayed in bed all day
2 Confined myself to a room away from my family and housemates
3 Stopped eating
4 Sleep disruption
5 Extreme loss of energy
6 Very anxious that I would not recover from COVID illness
7 Other,
Please specify other: [symp_events_other] _____
0 None of these apply

~~*for all endorsed in list:*~~
~~For how many days did you experience: (*insert item from symptoms_events*)? [symptoms_events_*item#*_days]~~
~~*(repeat for each symptom endorsed)*~~

16. How severe was your COVID illness? (check one) [how_severe_self]

1 Very mild
2 Mild to moderate
3 Moderate to severe
4 Severe to Extreme
5 Life-threatening
999 Unsure

III. COVID – Becoming Ill

17. What symptoms led you to seek medical attention? (check all that apply) [onset_symptoms]

1 Fever
2 Chills or Shaking
3 Cough
4 Difficulty Breathing
5 Chest pressure
6 Loss of Taste or Smell
7 Sore Throat
8 Runny Nose/Sinus Congestion
9 Diarrhea
10 Muscle Pain/Body Aches
11 Headache
12 Fatigue
13 Nausea/Vomiting
14 Seizure or Loss of Consciousness
15 I Received Care Before Noticing Symptoms
16 Other,
Please specify other: _____ [onset_symp_other]
0 None of these apply

18. When you realized you were sick, where did you initially go for medical assistance? (check one) [onset_provider]

1 Contacted medical provider by phone
2 Contacted medical provider over the internet
3 Was seen at a non-urgent medical office
4 An urgent care facility
5 A rapid testing location or drive-through
6 A hospital Emergency Room (ER)
7 Other
Other, specify _____ [onset_provider_other]
0 I did not seek help from a professional care provider about my COVID illness

19. Did you ever call 911 with concerns about your COVID illness? (check one) [onset_call_911]

1 Yes
0 No

If yes, then:

How many times? (check one) [calls_911]

1 one time
2 more than one time

IV. COVID – Work Impacts

20. What was your employment status at the time that you developed COVID illness? (check one) [employ]

1 Employed part-time
2 Employed full-time
3 On leave
4 Unemployed
5 None apply

If 1 or 2 or 3, then:

20.1 Did you take time off of work as a result of your COVID illness? (check one) [employ_time_off]

1 Yes
0 No

If yes, then:

20.1.1 How many days taken off work? (number) [employ_time_off_days]

If 1, then:

20.1.2 Did you lose income when you were not able to work? (check one) [employ_income_loss]

1 Yes
0 No
999 Unsure

IV. COVID Treatments

21. Which of the following at home treatments did you use? (check all that apply) [treat_home]

1 Rest
2 Fluids/Hydration
3 Acetaminophen
4 Ibuprofen
5 Cold and Flu medicine
6 Sleep aids
7 Other,
0 None of these apply

If 7, then:

21.1 Please specify other: (open field) [treat_home_other]

22. Were you admitted to the hospital as a result of your COVID illness? (check one) [treat_hospital]

1 Yes
0 No

If yes, then:

22.1 How long were you hospitalized (days)? (number) [treat_hospital_days]

If yes, then:

22.2 Which medical treatments did you receive? (check all that apply) [treat_med_therapy]

1 Transfer into a prone position (lying face down on your stomach) for extended periods of time
2 Admission to ICU or High Dependency Unit
3 Oxygen Therapy
4 Non-invasive Ventilation (such as continuous positive airway pressure/CPAP/BiPAP)
5 Invasive ventilation (Tracheostomy, Intubation)

6 Prolonged cardiac and respiratory support (Extracorporeal support)
7 IV fluids
8 Convalescent plasma (blood plasma taken from people who have recovered from COVID-19 and may have antibodies)
9 Renal replacement therapy (RRT) or dialysis?
10 Chest X-ray
11 Other kind of imaging such as Ultrasound, MRI, CT-Scan
12 Other
0 None of these apply

For items 1-7 list:

22.2.1 For how many days: (*insert item from treat_med_therapy*)? (check one) [treat_med_therapy_*item*]

1 1
2 2
3 3
4 4
5 5 or more
999 Unsure

For items 8-11 list:

22.2.2 How many times: (*insert item*)? (check one) [treat_med_therapy_*item*]

1 1
2 2
3 3
4 4
5 5 or more
999 Unsure

for item 12:

22.2.3 Please specify other: (open field) [treat_med_ther_other]

If 10, then:

22.2.4 Were infiltrates present? (Chest X-Ray) (check one) [treat_med_therapy_10_infil]

1 Yes
2 No
999 Unsure

23. Which medications have you been prescribed to treat your COVID-related illness? (check all that apply) [treat_prescriptions]

1 Hydroxychloroquine (Plaquenil)
2 Antibiotic (such as Azithromycin)
3 Remdesivir or other anti-viral
4 Immunosuppressive medication (such as Tocilizumab, Azathioprine)
5 Anti-inflammatory corticosteroid (such as Dexamethesone, Prednisone, Hydrocortisone, Interferon beta-1a)
6 Cardiovascular drug (such as Inotropes/vasopressors)
7 Antifungal
8 Other
0 None of these apply

If 8, then:

23.1 Please specify other: (open field) [treat_med_ther_other]

~~*For items 1-7 list:*~~

~~**22.2.1 For how many days: (*insert item from treat_prescriptions*)?** (check one)~~

~~[treat_med_therapy_*item*]~~

~~1 1~~
~~2 2~~
~~3 3~~
~~4 4~~
~~5 5 or more~~
~~999 Unsure~~

V. COVID Lasting Effects

24. Some people report lasting changes in their general health after they have fully recovered from COVID sickness. Did you experience any of the following general health changes as a possible result of your experience of having had COVID? (check all that apply) [lasting_changes]

1 Change in appetite
2 Trouble swallowing
3 Change in way foods taste
4 Unexpected weight change
5 Wheezing or shortness of breath
6 Sinus pressure
7 Dental problems
8 Ear pain
9 Hearing loss
10 Tinnitus (ringing in ears)
11 Voice change
12 Change in way things smell
13 Fatigue
14 Eye discharge, itching or redness
15 Light sensitivity or eye pain
16 Change in vision
17 Chest pain
18 Leg swelling
19 Heart palpitations or heart rate acceleration/deacceleration
20 Musculoskeletal symptoms (new pains or trouble walking)
21 Abdominal pain
22 Digestive problems
23 Hair loss
24 Skin irritation, rashes, itchiness
25 Excessive thirst or excessive urination
26 Mood symptoms (nervous, anxious, depressed mood, irritation)
27 Sleep disturbance
28 Light headedness or confusion
29 Other
0 None of these

If 29, then:

24.1 Please specify other: (open field) [lasting_changes_other]

If (any), then:

24.2 Have those lasting symptoms or complications resolved, or are they still ongoing? (check one) [lasting_current]

1 Resolved
2 Ongoing
999 Not applicable

25. Have you experienced any cognitive or memory problems as a result of your COVID illness? [lasting_cognitive]

1, Yes
0, No
999, I prefer not to answer

26. When do you expect to be fully recovered from your COVID illness and back to full health? (check one) [return_health_when]

0 I am fully recovered and healthy
1 Within 6 months
2 Within 12 months
3 Within 1-2 years
4 More than 3 years
5 It is unlikely I will regain full health, and long-term impact is likely to be mild
6 It is unlikely I will regain full health, and long-term impact is likely to be moderate
7 It is unlikely I will regain full health, and long-term impact is likely to be severe

If [lasting_changes]=26, then:

24. 1 What kind of lingering mood symptoms did you experience as a result of your COVID illness? (check one) [lasting_mood]

1, Depressed mood
2, Anxiety / nervousness
3, Irritation / short temper / agitation
4, Lack of feeling / loss of interest
0, None of these
5, Other

If other:

Please specify: (open field) [how_anxious_other]

If [lasting_cognitive=1], then

25. 1 What kind of cognitive or memory problems did you experience as a result of your COVID illness? (check all) [lasting_cognitive_detail]

1, Language
2, Attention
3, Long-term memory (e.g., where I was born)
4, Short-term memory (e.g., what I ate for breakfast)
5, Perception
6, Learning
7, Reasoning
8, Intelligence
9, None of these
10, Other

If other:

Please specify: (open field) [lasting_cognitive_other]

If [lasting_changes]<0, then:

24.2 How long did you experience lasting changes in your general health after fully recovering from COVID sickness? [lasting_changes_time]

1, less than 1 week
2, 1 week
3, 2 weeks
4, 3 weeks
5, 4 weeks
6, 5 weeks
7, 6 week
8, 7 weeks
9, 8 weeks
10, 9 weeks
12, 10 weeks
13, more than 10 weeks
0, I did not experience lasting changes
999, I prefer not to answer

VI. COVID Illness experience

27. How much anxiety did you have about being ill with the COVID virus? (check one) [how_anxious]

0 No anxiety
1 Very mild anxiety
2 Mild to moderate anxiety
3 Moderate to severe anxiety
4 Severe to Extreme anxiety
5 Extreme anxiety

If > 0 above, then:

26.1 What was your greatest source of anxiety? (open field) [why_anxious]

28. How much did your COVID illness disrupt your life? (check one) [how_disrupted]

0 No disruption
1 Very mild disruption
2 Mild to moderate disruption
3 Moderate to severe disruption
4 Severe to Extreme disruption
5 Extreme disruption

29. Which best describes your quarantine behavior when you were ill with COVID? (check one) [quarantine_kind_test]

0 **No quarantine**
1 **Limited quarantine:** Confined within home for fewer than 7 days, when possible avoided interactions with others in the home
2 **Living with others – partial avoidance:** confined within home for more than 7 days, avoided non-affected others when possible
3 **Living with others – restricted interactions:** confined within home; limited interactions with non-affected others within home and only while wearing a mask and socially distancing, for more than 7 days
4 **Living with others – complete isolation:** confined within home to specific spaces away from non-affected others for at least 7 days

5 **Independent living - isolation:** stayed in a residence by self for more than 7 days and rarely or never left residence

30. Were you satisfied with the medical care you received from medical professionals throughout your COVID illness? (check one) [med_care_rate]

1 Very satisfied
2 Moderately satisfied
3 Neutral
4 Moderately dissatisfied
5 Very dissatisfied
999 Unsure

31. Did any other individuals that live full-time in your household become ill with COVID? (check all that apply) [other_household_covid]

0 None
1 Partner/spouse
2 Your baby (younger than 12 months old)
3 One or more of your children (older than 12 months old)
4 Parent
5 Other

VII. Current Situation

32. In the last 10 days, have you: (check all that apply) [ten_days_activity_01]

1 Gone out to a restaurant, bar, club or other place where people gather?
2 Visited with friends, relatives or neighbors that are older than 60 years old?
3 Gone to the grocery store, pharmacy, food market?
4 Visited a retail store to buy non-food items such as clothing, decorations, gifts, sporting goods?
5 Visited with a friend, neighbor or relative?
6 Had food delivered to your home or ordered take-out/take-away at a restaurant?
7 Had more than 4 friends, neighbors or relatives over to your house at one time?
8 Shared a car ride with individuals not living in your home?
9 Taken public transportation?
10 Gone to a gathering where there were more than 10 people, such as a sports game, performance, reunion, wedding, funeral, party?
11 Gone to a faith based gathering such as a church, synagogue, temple or mosque?
0 None of these apply

33. Do you have pets in your home? (check all that apply) [pet]

1 Dog(s)
2 Cat(s)
3 Bird(s)
4 Reptile(s)
5 Rodent(s)
6 Fish
7 Other
0 None of these apply

If 7, then:
32.1 Please specify other: (open field) [pet_other]

For all endorsed in list:

32.2 How many (*insert item*)? (open field) [pet_*item*_num]

(repeat for each animal endorsed)

34. At this time have you received a COVID-19 Vaccine? (check one) [vaccine_received]

1 Yes (1 or 2 doses)
0 No
999 Unsure

If yes, then:

34.1 When did you receive the COVID-19 vaccine? (check one) [vaccine_received_date]

1. Prior to Jan 2021
2. Jan 2021
3. Feb 2021
4. March 2021
5. April 2021
6. May 2021
7. June 2021

If yes, then:

34.2 Which vaccine did you receive (choose one)? (check one) [which_vaccine]

1 Pfizer vaccine – First dose only
2 Pfizer vaccine – First and second dose
3 Moderna vaccine – First dose only
4 Moderna vaccine – First and second dose
5 Other
6 I do not know

If 6, then:

34.2.1 Which other vaccine did you receive? (check one) [which_vaccine_other]

1 AstraZeneca vaccine
2 Janssen vaccine
3 Novavax COVID-19 vaccine
4 Johnson and Johnson vaccine
0 None of these

If yes, then:

34.3 Did you experience any side effects within 2 weeks after the FIRST vaccine? (check one) [vaccine_had_side]

1 Yes
0 No
2 I do not know

If yes, then:

34.3.1 Which side effect did you experience (check all that apply) [vaccine_side_effects]

1 Pain where shot was given
2 Fever >100.4F
3 Fatigue/tiredness
4 Headache
5 Muscle pain in parts of your body beyond where shot was given
__ severe allergic reaction (including difficulty breathing and feeling faint, and possibly also skin rash, nausea and/or vomiting)

6 Skin rash
7 Facial swelling
8 Other (please describe)_____ [vaccine_side_effects_other]

If both doses; [which_vaccine] = 2 or [which_vaccine] = 4, then:

34.4 Did you experience any side effects within 2 weeks after the SECOND vaccine? (check one) [vaccine2_had_side]

1 Yes
0 No
2 I do not know

If yes, then:

34.4.1 Which side effect did you experience after your SECOND vaccine (check all that apply) [vaccine2_side_effects]

1 Pain where shot was given
2 Fever >100.4F
3 Fatigue/tiredness
4 Headache
5 Muscle pain in parts of your body beyond where shot was given
__ severe allergic reaction (including difficulty breathing and feeling faint, and possibly also skin rash, nausea and/or vomiting)
6 Skin rash
7 Facial swelling
8 Other (please describe)_____ [vaccine2_side_effects_other]

` *If [vaccine_received]= yes, then:*

34.5 Have you relaxed your COVID-19 safety behaviors (e.g., social distancing, mask wearing, travel) now that you have received the COVID-19 vaccine? (check one) [vaccine_relaxed_behavior]

1 Yes
0 No

If [vaccine_received]= no, then:

34.6 If you were offered the COVID vaccine tomorrow, what would you do? (check one) [if_offered_vaccine]

1 I would definitely choose to get vaccinated
2 I would probably choose to get vaccinated
3 I would probably choose NOT to get vaccinated
4 I would definitely NOT choose to get vaccinated

If [vaccine_received]= no, then:

34.7 Do you think you will relax your COVID-19 safety behaviors (e.g., social distancing, mask wearing, travel) once you receive the COVID-19 vaccine? (check one) [vaccine_will_relax_behavior]

1 Yes
0 No

35. Do you have children? (indicate yes if pregnant now, partner of pregnant female, or are trying to conceive) (check one) [has_children]

1 Yes
0 No

If yes, then:

35.1 What are the ages of your children? (check all that apply) [ages_of_children]

0 Currently pregnant / or partner of pregnant female
1 1 year
2 2 years
3 3 years
4 4 years
5 5 years
6 6 years
7 7 years
8 8 years
9 9 years
10 10 years
11 11 years
12 12 years
13 13 years
14 14 years
15 15 years
16 16 years
17 17 years
18 18 years
20 Older than 18
19 Trying to conceive
21 0-12 months

If female, and answered yes, and infant under 12 mo, then:

35.2 Are you currently breastfeeding an infant? (check one) [breastfeeding infant]

1 Yes
0 No
2 I do not know

If yes and received vaccination, then:

35.2.1 Did your breastfeeding baby experience any side effects following your vaccination? (check one) [breastfeeding_baby_side_effects]

1 Yes
0 No
2 I do not know

If yes:

35.2.1.1 Which side effect did your infant experience? (check all that apply) [infant_side_effects]

1 Fatigue/tiredness
2 Immediate allergic reaction
3 Skin rash
4 Facial swelling
5 Eczema or itchy, cracked, and rough skin
6 Other (please describe)_____[infant_side_effect_other]

If female AND if has not had vaccine AND if pregnant OR breastfeeding:

35.3 Which of the following applies to your plans about the COVID vaccine? (check one) [covid_vaccine_plans]

1 I plan on getting the COVID vaccine as soon as it is available to me

2 I plan on getting the COVID vaccine when I am no longer pregnant
3 I plan on getting the COVID vaccine later in my pregnancy
4 I plan on getting the COVID vaccine when I am no longer breastfeeding
5 I do not plan on getting the COVID vaccine

If has child, then:

35.4 Has your child (or children) been infected with COVID? (check one) [children_infected]

1 Yes, and tested positive or had antibodies
2 Yes, was ill but not confirmed with formal testing
3 No, my child (or children) have not been infected with COVID
999 I am unsure

If yes, then:

35.4.1: Ages of children infected with COVID: (open field) [children_infected_ages]

36. Which of the following applies to your plans about the COVID vaccine for your child(ren)? (check one) [vaccine_children]

1 I plan on getting the COVID vaccine for my child(ren) as soon as it is available
2 I plan on getting the COVID vaccine for my child(ren) eventually
3 I do not plan on getting the COVID vaccine for my child(ren)
4 I am unsure

Annotation: Novel Coronavirus (COVID) Illness – Patient Report (NCIPR) is a self-report measure of coronavirus testing, timing, symptoms and treatments. This is a self guided, patient-facing measure. It is recommended that this be administered with the NCIPR-Demographics measure, which includes participant age, brief medical history and additional relevant domains.

Scoring and interpretation: The scale provides descriptive account of illness symptoms and treatment, provides items that can be referenced to evaluate illness severity, contains self-assessment of anxiety and disruption, and asks about satisfaction with medical care. Psychometric properties of the measure are not yet available, but the following suggestions are made:

- Quality check of data can be performed based on the following items:
  - Give covid illness date before that date has happened (ncipr_onset_date)
- Symptom severity can be assessed based on the following items:
  - Length of fever [ncipr_symptoms_all_01_days2]
  - Was your fever ever greater than 103.0 F/39.4 C? [ncipr_fever_level]
  - [ncipr_symptoms_med_complicat]
  - How severe was your COVID illness? [ncipr_how_severe_self]
  - Were you admitted to the hospital as a result of your COVID illness? [treat_hospital]
  - How much did your COVID illness disrupt your life? [how_disrupted]
- Stress and anxiety can be assessed based on the following items:
  - Please rate your current stress level [db_31 – in the NCIPR-Demographics measure]
  - How much anxiety did you have about being ill with the COVID virus? (check one) [how_anxious]
- Most troubling symptom is assessed by [ncipr_symptom_worst]
- Lingering symptoms (post acute sequale of COVID) is assessed by [lasting_changes]

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