Version: 3.0, 8/10/2020

HEROS Study

(Human Epidemiology and RespOnse to SARS-CoV-2)

Every-Other-Week Questionnaire and Specimen Collection

Question Tree Structure

1. Symptom Assessment
    a. Were you sick since your last survey (about 7 days ago)? Yes/No
    IF YES: Section Header Intro Text: We are sorry you haven't been feeling well. Below is a list of symptoms - please indicate if you have experienced any of the following symptoms since your last survey
        i. Symptom List Hierarchy (Bold Questions) with Subcategories(*subcategories are only shown if bolded questions are endorsed "YES"*)
            1. **Did you have a fever or feel feverish (chills, sweating) at any time since your last survey** (about 7 days ago)**?** Yes/No
                a. What was your highest temperature? Integer response
                    a. Is this in Fahrenheit or Celsius?
                b. Approximately how many days in the last week did you have fever or feel feverish (chills, sweating)?
                c. Do you currently have a fever or feel feverish (chills, sweating)? Yes/No
            2. **Did you have any cold or flu-like symptoms (such as a sore throat, runny nose, or congestion) at any time since your last survey** (about 7 days ago)**? Yes/No**
                a. Approximately how many days in the last week did you experience these symptom(s)?
                b. Are you currently experiencing any cold or flu-like symptoms? Yes/No
            3. **Did you have a cough at any time since your last survey** (about 7 days ago)**?** Yes/No
                a. Approximately how many days in the last week did you have a cough?
                b. Are you currently experiencing any coughing? Yes/No
            4. **Did you have any wheezing or whistling in the chest at any time since your last survey** (about 7 days ago)**?** Yes/No
                a. Approximately how many days in the last week did you have any wheezing or whistling in the chest?
                b. Are you currently experiencing any wheezing or whistling in the chest? Yes/No
            5. **Did you have any shortness of breath at any time since your last survey** (about 7 days ago)**? Yes/No**
                a. Approximately how many days in the last week did you have any shortness of breath?
                b. Are you currently experiencing any shortness of breath? Yes/No

6. **Did you have any pain or discomfort in your chest at any time since your last survey** (about 7 days ago)**?** Yes/No
    a. Approximately how many days in the last week did you have pain or discomfort in your chest?
7. **Did you feel tired or fatigued at any time since your last survey** (about 7 days ago)**?**
    a. Approximately how many days in the last week did you feel tired or fatigued?
    b. Are you currently experiencing any feelings of being tired or fatigued? Yes/No
8. **Did you have any body aches at any time since your last survey** (about 7 days ago)**? Yes/No**
    a. Approximately how many days in the last week did you have any body aches?
    b. Are you currently experiencing any body aches? Yes/No
9. **Did you have any headaches at any time since your last survey** (about 7 days ago)**? Yes/No**
    a. Approximately how many days in the last week did you have any headaches?
    b. Are you currently experiencing any headaches? Yes/No
10. **Did you have any ear pain at any time since your last survey** (about 7 days ago)**? Yes/No**
    a. Approximately how many days in the last week did you have any ear pain?
    b. Are you currently experiencing any ear pain? Yes/No
11. **Did you have a problem with your ability to smell, such as not being able to smell things or things not smelling the way they are supposed to since your last survey** (about 7 days ago)**? Yes/No**
    a. Approximately how many days in the last week did you have a problem with your ability to smell?
    b. Are you currently experiencing any change in your ability to smell? Yes/No
12. **Did you have a problem with your ability to taste sweet, sour, salty, or bitter foods and drinks since your last survey** (about 7 days ago)**? Yes/No**
    a. Approximately how many days in the last week did you have a problem with your ability to taste?
    b. Are you currently experiencing any change in your ability to taste? Yes/No
13. **Did you experience any nausea (feeling that you might vomit) at any time since your last survey** (about 7 days ago)**?**
    a. Approximately how many days in the last week did you experience any nausea?
    b. Are you currently experiencing any nausea? Yes/No

14. **Did you have diarrhea (any loose or watery stools) at any time since your last survey** (about 7 days ago)**?**
    a. Approximately how many days in the last week did you have diarrhea?
    b. Are you currently experiencing any diarrhea? Yes/No
15. **Did you have belly pain at any time since your last survey** (about 7 days ago)**?**
    a. Approximately how many days in the last week did you have belly pain?
    b. Are you currently experiencing any belly pain? Yes/No
16. **Did you have red or pink eyes at any time since your last survey** (about 7 days ago)**?**
    a. Approximately how many days in the last week did you have red or pink eyes?
    b. Are you currently experiencing any red or pink eyes? Yes/No
17. **Did you experience any other symptoms not listed above since your last survey** (about 7 days ago)**? Yes/No**
    a. How many additional symptoms have you experienced?[integer response](repeating the below a-c for each symptom endorsed)
        a. Please describe symptom 1 [text box]
        b. Approximately how many days in the last week did you experience symptom 1?
        c. Are you currently experiencing this symptom?

ii. Repeated Question #1-2 from baseline survey
1. Has a doctor told you that you or anyone in your family may have coronavirus, SARS-CoV-2, or COVID-19? Yes (specify how many participating family members and their names)/No
    a. *1=yes* 1a. Do you know how [**NAME**] got coronavirus (or SARS-CoV-2 or COVID-19)? Yes (specify)/No
        a. *1=yes* 1b. Was [**NAME**] hospitalized for coronavirus (or SARS-CoV-2 or COVID-19)? Yes/No
            1. *1b=yes* 1b1. While in the hospital, was he/she...? Select all that apply.
                a. Admitted to the intensive care unit
                b. Put on a ventilator (a machine that pushes air into and out of your lungs)
                c. Given oxygen (a mask or tubes in your nose that give you extra air to breathe)
                d. Given antibiotics or other treatment (if selected, specify)
    b. *1=no* 1c. Do you think you or anyone in your family has had coronavirus (or SARS-CoV-2 or COVID-19)? Yes/No

c. *1=no* 1d How likely do you think it is for you or someone in your family to catch coronavirus (or SARS-CoV-2 or COVID-19)? If you are not sure, just take your best guess.
d. Very likely
e. Likely
f. Not very likely
g. Not likely at all

2. Have you or someone in your family been in contact with someone who tested positive for coronavirus (or SARS-CoV-2 or COVID-19)? Yes/No

b. Was **anyone in your house sick since your last survey** (about 7 days ago)**?**
   i. Who in your household is sick (checkbox for options)
   ii. Repeat 1-10 Symptom assessment for each member of the household
      1. Child Specific Questions

2. Exposure Risk and Prevention Activities:
   a. In the last week, did you or anyone in your family:(Checklist)
      i. Travel outside of the city or town that you live in
      ii. Travel on a plane
      iii. Travel outside of the United States
      iv. Go to work
      v. Go to school
      vi. Go to daycare
      vii. Go to the grocery store
      viii. Go to a scheduled healthcare appointment
      ix. Go out to eat
      x. Spend time with friends or family that do not live with you
      xi. Go to gatherings, such as church or concerts
      xii. Bring take-out food home
      xiii. Go to a sick visit (for example, a visit to your doctor, urgent care center, emergency room, or hospital)
3. Thinking about these activities in the last week, my social interaction (direct contact with people outside my home such as when shopping, working, care-giving or volunteering) was:
      i. A lot less than normal
      ii. Somewhat less than normal
      iii. About the same as normal
      iv. More than normal

Item References-

Symptom Domain	Source of Questions
Fever	WURSS-24
Cough	WURSS-24

Wheezing	International Study of Asthma and Allergies in Childhood (ISAAC)
Chest Pain/Tightness	Rose Chest Pain Questionnaire
Fatigue	Adult Quality of Life
	WURSS-24
Anosmia	NHANES 2011 Chemical Smell and Taste Loss
Dysgeusia	NHANES 2011 Chemical Smell and Taste Loss
GastroIntestinal	PROMIS Nausea and Vomiting
GastroIntestinal	PROMIS Gastrointestinal Diarrhea
GastroIntestinal	PROMIS Belly Pain
Exposure Risk	COVD Draft Questionnaire for CLSA
Social distancing	State of Michigan social distancing survey (from Chris Johnson)