COVID-19 Questionnaire

Please complete the survey below.

Date of Birth *Required

_____
(mm-dd-yyyy)

Initials

_____
(Please write your FIRST and LAST initial only.)

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1) Where do you CURRENTLY live? *Required

◯ Independent home or other housing in the general community
◯ Senior/retirement housing or community for people age 55+
◯ Assisted living facility
◯ Rehabilitation facility or skilled nursing facility
◯ Nursing home

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2) With whom do you live? (Mark all that apply.) *Required

☐ Alone
☐ With spouse or partner
☐ With other family
☐ With non-relatives

QUESTIONS ABOUT CORONAVIRUS (COVID-19)

3) Have you been tested for the coronavirus (COVID-19, SARS-CoV-2)? *Required

- ◯ No
- ◯ Yes
- ◯ Not Sure

Have you had at least one test with a POSITIVE result? *Required
[Only shows if "Yes" is selected for Question 3]

- ◯ No
- ◯ Yes
- ◯ Not Sure

Please answer the following questions about the NEGATIVE test result(s) you received. [Only shows if "No" is selected for "Have you had at least one test with a POSITIVE result?"]

How many times were you tested? *Required
[Only shows if "No" or "Not Sure" is selected for "Have you had at least one test with a POSITIVE result?"]

- ◯ 1 time
- ◯ 2 times
- ◯ 3 or more times
- ◯ Not Sure

Please answer the following questions about the POSITIVE test result(s) you received. [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

When were you tested? Mark all that apply. *Required
[Shows if "No" or "Yes" or "Not Sure" is selected for "Have you had at least one test with a POSITIVE result?"]

- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May

Where was the test performed? Mark all that apply. *Required
[Shows if "No" or "Yes" or "Not Sure" is selected for "Have you had at least one test with a POSITIVE result?"]

- ☐ Hospital - Emergency Department
- ☐ Hospital - Inpatient
- ☐ Outpatient Clinic
- ☐ Drive-Through
- ☐ Other

The following question(s) are about ANY NEGATIVE test results you may have received. [Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

Have you had any negative test results? *Required
[Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

- ◯ No
- ◯ Yes
- ◯ Not Sure

How many times have you had a negative test result? *Required
[Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

- ◯ 1 time
- ◯ 2 times
- ◯ 3 or more times
- ◯ Not Sure

Where was the test performed? Mark all that apply. *Required
[Only shows if "Yes" is selected for "Have you had at least one test with a POSITIVE result?"]

- ☐ Hospital - Emergency Department
- ☐ Hospital - Inpatient
- ☐ Outpatient Clinic
- ☐ Drive-Through
- ☐ Other

4) Whether or not you have had a coronavirus test, has a doctor or another healthcare professional diagnosed you as having or probably having the coronavirus? *Required

- ◯ No
- ◯ Yes
- ◯ Not Sure

5) To your knowledge, have you EVER been exposed to another person with confirmed or suspected COVID-19 as part of the pandemic? *Required

◯ Yes, confirmed COVID-19 case(s)
◯ Yes, suspected COVID-19 case(s) only
◯ Yes, both confirmed and suspected COVID-19 case(s)
◯ No, not that I know of

Were any of these cases a member of your household? *Required ◯ No ◯ Yes [Shows if "Yes..." is selected in the question above]

6) Since January 2020, have you had any of the following symptoms that may or may not be related to COVID-19?

a) Fever *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

[Sub-questions for Questions 6a-6p only show if "Yes" is selected for the symptom question]

☐ January ☐ February ☐ March ☐ April ☐ May

b) Persistent cough (coughing a lot for more than 1 hour, or at least 3 coughing episodes in 24 hours) *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

c) Chills or sweats *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

d) Unusual fatigue *Required ◯ No ◯ Yes

What was the severity? *Required

◯ Mild Fatigue
◯ Severe Fatigue

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

e) Headache *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

f) Unusual shortness of breath *Required ◯ No ◯ Yes

What was the severity? *Required

◯ Mild (slight shortness of breath during ordinary activity)
◯ Significant (breathing is comfortable only at rest)
◯ Severe (breathing is difficult even at rest)

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

g) Sore throat *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

h) Loss of smell *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

i) Loss of taste *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

j) Loss of appetite (including skipped or missed meals) *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

k) Unusually hoarse voice *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

l) Unusual chest pain or tightness in your chest *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

m) Muscle or body aches *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

n) Unusual abdominal pain *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

o) Diarrhea *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

p) Confusion, disorientation, or drowsiness *Required ◯ No ◯ Yes

When since January 2020? *Required
(Mark all that apply.)

☐ January ☐ February ☐ March ☐ April ☐ May

7) Which of the following statements applies to you? Mark all that apply. *Required

- ☐ I haven't been to a clinic, emergency room, or hospital for suspected COVID-19 symptoms.
- ☐ I was evaluated at a clinic, emergency room, or hospital with suspected COVID-19 symptoms.
- ☐ I was hospitalized for COVID-19.

a) What treatment did you receive? Mark all that apply. *Required [Sub-questions for Question 7 (a-e) only show if "I was hospitalized for COVID-19" is selected]

- ☐ Intravenous fluids
- ☐ Oxygen through nasal (nose) prongs or facial mask, but not requiring a ventilator
- ☐ Invasive ventilation or ventilator (Breathing support through an inserted tube. People are usually asleep for this procedure.)
- ☐ CPAP/BiPAP
- ☐ ECMO (a machine that supplies oxygen to the blood when it circulates outside the body)
- ☐ None of the above
- ☐ Other

Please specify treatment: *Required

_____

b) Did you require treatment in an Intensive Care Unit (ICU)? *Required

- ◯ No
- ◯ Yes
- ◯ Not Sure

How many days were you in the ICU? *Required

- ◯ 1 day
- ◯ 2 days
- ◯ 3 days
- ◯ 4 or more days
- ◯ Not Sure

c) What was the TOTAL DURATION of your hospitalization? *Required

- ◯ Less than 3 days
- ◯ 3-5 days
- ◯ 6-9 days
- ◯ 10 or more days
- ◯ Not Sure

d) Are you now out of the hospital? *Required

- ◯ No
- ◯ Yes

Where were you discharged to from the hospital? *Required
[Only shows if "Yes" is selected for Q7d and answer to Q1 was NOT "Rehabiliation.."]

- ◯ [q1_live_where]
- ◯ Rehabilitation facility or skilled nursing facility
- ◯ Other

e) Would you be willing to sign and return a medical record release form to allow us to request medical records from facilities involved with your COVID-19 hospitalization? This is optional and does not impact participation in the study.

- ◯ No
- ◯ Yes

We will send this medical record request form to you by mail as soon as possible, thank you.
Please continue to next page. [Only shows if "Yes" is selected for Q7e]

MOBILITY AND OUTCOMES

8) CURRENTLY, do you regularly use a cane, walker, or wheelchair to get about?

◯ No ◯ Yes

9) In general, do you have any health problems that require you to limit your activities?

◯ No ◯ Yes

10) OVER THE PAST MONTH, how would you describe your level of physical activity or exercise, compared to your average physical activity level before the COVID-19 pandemic began?

◯ Much less ◯ Somewhat less ◯ About the same ◯ Somewhat more ◯ Much more

11) Have you EVER been diagnosed with any of the following conditions?

Please be sure to repeat your reports when you receive your next usual questionnaire for [dpm_study] within the next year [Sub-questions for Questions 11a-11r: "When were you Dx?" only shows if "Yes" is selected; "Which month?" only shows if "After January 1, 2020" is selected]

a) Pneumonia *Required — ◯ No ◯ Yes

When were you diagnosed? *Required
◯ Before January 1, 2020
◯ After January 1, 2020

Which month? *Required
◯ January 2020
◯ February 2020
◯ March 2020
◯ April 2020
◯ May 2020
◯ Not Sure

b) Influenza (flu) *Required — ◯ No ◯ Yes

When were you diagnosed? *Required
◯ Before January 1, 2020
◯ After January 1, 2020

Which month? *Required
◯ January 2020
◯ February 2020
◯ March 2020
◯ April 2020
◯ May 2020
◯ Not Sure

c) Chronic obstructive pulmonary disease (COPD) *Required — ◯ No ◯ Yes

When were you diagnosed? *Required
◯ Before January 1, 2020
◯ After January 1, 2020

Which month? *Required
◯ January 2020
◯ February 2020
◯ March 2020
◯ April 2020
◯ May 2020
◯ Not Sure

d) Asthma *Required — ◯ No ◯ Yes

When were you diagnosed? *Required
◯ Before January 1, 2020
◯ After January 1, 2020

Which month? *Required
◯ January 2020
◯ February 2020
◯ March 2020
◯ April 2020
◯ May 2020
◯ Not Sure

e) Other lung disease (not including cancer) *Required — ◯ No ◯ Yes

When were you diagnosed? *Required
◯ Before January 1, 2020
◯ After January 1, 2020

Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
f) Melanoma *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
g) Non-melanoma skin cancer *Required	◯ No ◯ Yes
Which type? *Required	◯ Squamous cell ◯ Basal cell ◯ Not Sure
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
h) Cancer (not including skin cancer) *Required	◯ No ◯ Yes
Please specify site:	_____
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
i) Heart attack or myocardial infarction *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020

Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
j) Coronary artery bypass surgery *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
k) Coronary angioplasty or stent (balloon used to unblock an artery) *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
l) Heart failure (congestive heart failure) *Required	◯ No ◯ Yes
Were you hospitalized? *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
m) Stroke *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure

n) Hypertension (high blood pressure) *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
o) Diabetes *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
p) Kidney failure or dialysis *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
q) Atrial fibrillation *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020
Which month? *Required	◯ January 2020 ◯ February 2020 ◯ March 2020 ◯ April 2020 ◯ May 2020 ◯ Not Sure
r) Autoimmune diseases (rheumatoid arthritis, lupus, Crohn's disease, psoriasis) *Required	◯ No ◯ Yes
When were you diagnosed? *Required	◯ Before January 1, 2020 ◯ After January 1, 2020

Which month? *Required

- ◯ January 2020
- ◯ February 2020
- ◯ March 2020
- ◯ April 2020
- ◯ May 2020
- ◯ Not Sure

MEDICATIONS

12) Are you CURRENTLY taking any medications for high blood pressure?

- ◯ No
- ◯ Yes
- ◯ Not Sure

Which high blood pressure medications are you taking? Mark all that apply. [Only shows if "Yes" is selected in Question 12]

- ☐ Beta-blockers (Examples: atenolol, metoprolol, Carvedilol)
- ☐ Calcium channel blockers (Examples: amlodipine, diltiazem)
- ☐ Thiazide diuretics (Examples: hydrochlorothiazide, chlorthalidone, Moduretic, Dyazide, indapamide)
- ☐ Loop diuretics (Examples: furosemide, Lasix, torsemide, Bumex, ethacrynic acid)
- ☐ ACE-inhibitors (Examples: lisinopril, enalapril, ramipril, captopril, benazepril)
- ☐ Angiotensin receptor blockers (Examples: valsartan, irbesartan, Entresto, losartan, candesartan, olmesartan)
- ☐ Aldosterone receptor blockers (Examples: spironolactone, eplerenone)
- ☐ Alpha-blockers (Examples: terazosin, doxazosin)
- ☐ None of these medications

13) Are you CURRENTLY taking any medications for diabetes?

- ◯ No
- ◯ Yes
- ◯ Not Sure

Which diabetes medications are you taking? Mark all that apply. [Only shows if "Yes" is selected in Question 13]

- ☐ Insulin injections
- ☐ SGLT2 inhibitors (Jardiance, Invokana, Dapagliflozin)
- ☐ Glucophage (metformin)
- ☐ Non-insulin injections/GLP1 agonists (Examples: exenatide, Byetta, Ozempic, Victoza, Trulicity)
- ☐ Sulfonylurea (Examples: Glucotrol (glipizide), glimepiride, chlorpropamide)
- ☐ Other oral drugs (Examples: Avandia, Prandin, Januvia, Starlix, Actos)
- ☐ None of these medications

14) Are you CURRENTLY taking any of the following:

	No	Yes
a) Statin drugs to lower cholesterol (Examples: Lipitor, Zocor, Mevacor, Pravachol, Crestor)	○	○
b) Non-statin drugs to lower cholesterol (Examples: niacin, Lopid, Questran, Colestid, Zetia, Praluent, Repatha)	○	○
c) Antiplatelet medication (Examples: clopidogrel, Plavix, prasugrel, Effient, ticagrelor, Brilinta, Zontivity)	○	○
d) Anti-coagulant drugs (Examples: warfarin, Coumadin, heparin, dabigatran, Pradaxa, rivaroxaban, Xarelto, Savaysa, Eliquis, Lovenox)	○	○

Antibiotics

	No	Yes
e) Azithromycin	○	○
f) Other antibiotics	○	○

Immunosuppressant medications

	No	Yes
g) Corticosteroids or prednisone	○	○
h) Methotrexate	○	○
i) IL-6 inhibitors (Examples: Actemra, Sylvant)	○	○
j) TNF blockers (Examples: Enbrel, Remicade, Humira)	○	○
k) Other biologic agents (Examples: Rituxan, Orencia)	○	○
l) Chloroquine or hydroxychloroquine	○	○

Over-the-counter medications

	No	Yes
m) Tylenol (acetaminophen)	○	○
n) Aspirin	○	○
o) Ibuprofen	○	○
p) Naproxen	○	○
q) Nurofen	○	○
r) Diclofenac	○	○
s) Other Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (Examples: Alka Seltzer, Excedrin, Celebrex)	○	○

GENERAL HEALTH

15) How do you feel physically right now?

◯ I feel physically normal or in my usual state of health
◯ I'm not feeling quite right compared to my usual health

16) Since January 1, 2020, have any of the following IN-PERSON, IN-CLINIC appointments for your regular care been cancelled or missed? ["Did you have a telehealth.." sub-question only shows if "Yes" is selected]

	No	Yes	Not Applicable
Annual health checkup	◯	◯	◯
Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?	◯	◯	◯
Primary care or general internist	◯	◯	◯
Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?	◯	◯	◯
Cardiologist	◯	◯	◯
Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?	◯	◯	◯
Oncologist	◯	◯	◯
Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?	◯	◯	◯
Elective procedures	◯	◯	◯
Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?	◯	◯	◯
Other	◯	◯	◯
Did you have a telehealth (e.g. phone call) or virtual (e.g. FaceTime) visit instead?	◯	◯	◯

17) We would like to know how good or bad your health is TODAY. The scale below is numbered from 0 (the worst health you can imagine) to 10 (the best health you can imagine).

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

18) What is your blood type?

◯ A
◯ B
◯ AB
◯ O
◯ Not Sure

19) What is your Rh Factor?

◯ Negative
◯ Positive
◯ Not Sure

20) Physical and Emotional Well-Being

a) How concerned are you about the COVID-19 pandemic?

◯ Not at all concerned
◯ Somewhat concerned
◯ Very concerned

b) What types of social or physical distancing steps are you taking? Mark all that apply.
By social or physical distancing, we mean steps you are taking to reducing amount of close physical contact you have with other people.

☐ Fewer social gatherings
☐ Avoid shopping
☐ Avoid public spaces like restaurants and theaters
☐ Avoid interactions with friends
☐ Avoid interactions with family
☐ Isolation from person(s) that live in your house
☐ Less physical activity or exercise
☐ I am not taking any social distancing steps
☐ Other

Please specify: [Only shows if "Other" is selected in 20b]

_____

c) Compared to the months before the COVID-19 pandemic began, how has the frequency of your communication with close friends and family changed?

◯ I communicate with them more frequently than before
◯ I communicate with them about the same as before
◯ I communicate with them far less often than before

d) How are you continuing to stay in touch with others? Mark all that apply.

☐ Speaking in person
☐ With phone calls
☐ With video calls
☐ By email
☐ By social media
☐ By postal mail
☐ Other

Please specify: [Only shows if "Other" is selected in 20d]

_____

e) How often are you communicating with others?

◯ Every day
◯ Several times per week
◯ 1-2 times per week
◯ Once per week
◯ Rarely or never

f) Who is providing you with social support during the outbreak? Mark all that apply.

- ☐ Someone I live with
- ☐ Friend or family who comes by my house
- ☐ Friend or family whom I talk with on the phone (or video chat)
- ☐ I do not have support
- ☐ Other

Please specify: [Only shows if "Other" is selected in 20f]

_____

g) How much difficulty do you have obtaining the food that you need because of the COVID-19 pandemic or social distancing rules?	◯ No difficulty ◯ Some difficulty ◯ Much difficulty ◯ Unable to obtain or very difficult
h) How much difficulty do you have obtaining the medicine that you need because of the COVID-19 pandemic or social distancing rules?	◯ No difficulty ◯ Some difficulty ◯ Much difficulty ◯ Unable to obtain or very difficult
i) How much difficulty do you have with getting routine medical care that you need because of the COVID-19 pandemic or social distancing rules?	◯ No difficulty ◯ Some difficulty ◯ Much difficulty ◯ Unable to obtain or very difficult
j) How much has your sleep been interrupted or disturbed because of concern about the outbreak?	◯ Hardly ever ◯ Some of the time ◯ Often
k) How often do you feel that you lack companionship?	◯ Hardly ever ◯ Some of the time ◯ Often
l) How often do you feel left out?	◯ Hardly ever ◯ Some of the time ◯ Often
m) How often do you feel isolated from others?	◯ Hardly ever ◯ Some of the time ◯ Often

n) Over the PAST 2 WEEKS, how often have you been bothered by any of the following?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	◯	◯	◯	◯
b. Feeling down, depressed, or hopeless	◯	◯	◯	◯

21) Did you get a flu vaccination after August 2019?	◯ No ◯ Yes ◯ Not Sure
22) Do you currently smoke cigarettes?	◯ No ◯ Yes
On average, how many cigarettes per day do you smoke? (1 pack = 20 cigarettes)	◯ Less than 5 ◯ 5-14 ◯ 15-24 ◯ 25-34 ◯ 35-44 ◯ 45 or more ◯ Not a current smoker
23) Do you vape or use electronic cigarettes (e-cigs)?	◯ No ◯ Yes

24) Since January 1, 2020, for each beverage listed, fill in the circle indicating how often on average you have used the amount specified.

	Never, or less than once per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Beer (1 glass, bottle, can)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Red wine (5 oz glass)	◯	◯	◯	◯	◯	◯	◯	◯	◯
White wine (5 oz glass)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Liquor, e.g., whiskey, gin, vodka (1 drink or shot)	◯	◯	◯	◯	◯	◯	◯	◯	◯

Please do not include the COSMOS study pills for this question. [Only shows for COSMOS participants]

25) Are you CURRENTLY taking a multivitamin (Examples: Centrum, One-A-Day, PreserVision)?

◯ No
◯ Yes

Please do not include the COSMOS study pills for this question. [Only shows for COSMOS participants]

26) NOT including your diet, how much TOTAL vitamin D do you take each day from nutritional supplements such as single tablets of vitamin D, multi-vitamins, calcium supplements (Calcium+D) or drugs that may include vitamin D (Example: Fosamax+D)? Referring to package labels, please add up ALL your non-diet sources of vitamin D.

◯ None
◯ 400 IU or less per day
◯ 401-800 IU per day
◯ 801-1000 IU per day
◯ 1001-2000 IU per day
◯ 2001-3000 IU per day
◯ 3001-4000 IU per day
◯ Greater than 4000 IU per day
◯ Large dose weekly or monthly
◯ Don't know

27) Are you CURRENTLY taking any of the following individual supplements? Please do not report the contents from multivitamins.

Vitamin C

◯ No
◯ Yes

How much?

◯ Less than 101 mg per day
◯ 101-500 mg per day
◯ 501-1000 mg per day
◯ 1001-2000 mg per day
◯ Greater than 2000 mg per day
◯ Don't know

Zinc

◯ No
◯ Yes

How much?

◯ Less than 25 mg per day
◯ 25-74 mg per day
◯ 75-100 mg per day
◯ Greater than 101 mg per day
◯ Don't know

28) Are there other individual supplements that you CURRENTLY take on a regular basis? Mark all that apply.

- ☐ B-complex
- ☐ Beta-carotene
- ☐ Calcium
- ☐ Choline
- ☐ Chromium
- ☐ Coenzyme Q10
- ☐ Cod liver oil
- ☐ Flax seed
- ☐ Flax seed oil
- ☐ Fish oil
- ☐ Folic acid
- ☐ Iron
- ☐ Lecithin
- ☐ Lycopene
- ☐ Magnesium
- ☐ Metamucil/Citrucel
- ☐ Niacin
- ☐ Potassium
- ☐ Selenium
- ☐ Vitamin A
- ☐ Vitamin B-6
- ☐ Vitamin B-12
- ☐ Vitamin E
- ☐ Vitamin K
- ☐ I don't take other supplements on a regular basis
- ☐ Other

Please specify: [Only shows if "Other" is selected" in Question 28]

_____

29) How much do you currently weigh without your shoes on?

_____
(Pounds)

30) Optional: Would you be willing to provide a blood or saliva sample by mail on your own (e.g. with a fingerprick or simple collection device) to gather additional important information related to the COVID-19 pandemic?

(You can still take part in this important sub-study and the overall [dpm_study] study if you prefer not to provide a sample.)

- ◯ No
- ◯ Yes
- ◯ Not Sure

Please indicate who completed this survey.

- ◯ Study participant
- ◯ Spouse or family member on behalf of study participant