WHI COVID-19 Survey 2

Please complete the survey below.

Thank you!

WHI timestamp

_____

Some of the questions below refer to the time you last provided information on COVID-19. You completed that questionnaire on: [date_last_surveyed]

Throughout this questionnaire, you will be asked about your experiences that relate to the current COVID-19 pandemic. We use the term COVID-19 to refer to the illness caused by the novel coronavirus that was first identified in 2019 and is also called SARS-CoV-2.

SECTION ONE:

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1. Who is completing this form?

◯ Self (WHI Study participant)
◯ Other, on behalf of WHI participant

1.1 Name and relationship to participant:

_____

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2. What is the ZIP code where you are currently living?

_____

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3. When you think about well-being, think about your physical health, your emotional health, any challenges you are experiencing, the people in your life, and the opportunities or resources available to you. How would you describe your current level of well-being?

◯ Excellent
◯ Very Good
◯ Good
◯ Fair
◯ Poor
◯ Very Poor

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4. Since [date_last_surveyed], have your living arrangements, including the place where you live and the people who live with you, changed due to the COVID-19 pandemic?

◯ No
◯ Yes

4.1 What has changed in your living arrangements? Mark all that apply.

☐ I moved to live with other family members or friends
☐ Other family or friends moved in with me
☐ Some household members moved away to limit the possibility of infection
☐ I moved out of shared housing to limit the possibility of infection
☐ A care provider/companion now comes to help me
☐ My care provider/companion no longer comes to help me
☐ I have moved into a care facility
☐ I have moved out of a care facility
☐ Other

4.1.1 Other (specify):

_____

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5. Do you live in a private home?

◯ Yes
◯ No

5.1 Including yourself, how many people currently live in your household?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more
5.2 Are any of the services and/or restrictions listed below in place where you currently live as a result of the COVID-19 pandemic? Mark all that apply.	☐ Residents are not allowed to leave their home/apartment/room ☐ Residents are not allowed to have visitors ☐ Residents are not allowed to leave the property except for emergencies ☐ Food is delivered to the home/apartment/room ☐ There are no restrictions on residents
6. Has anyone in your family or a close friend died from COVID-19?	◯ Yes ◯ No
6.1 Who have you lost to COVID-19? Mark all that apply.	☐ Spouse or partner ☐ Parent ☐ Child ☐ Other family ☐ Friend(s)
6.2 Did this person (or any of these people) live with you?	◯ No ◯ Yes

SECTION TWO: The next set of questions ask about COVID-19 vaccines, exposures, testing and medical care.

7. Have you received a COVID-19 vaccine?	◯ Yes ◯ No
7.1 Which vaccine did you get?	◯ Johnson and Johnson (Janssen) ◯ Pfizer ◯ Moderna ◯ Astra Zeneca ◯ Other or don't know
7.2 How many doses have you received?	◯ One shot ◯ Two shots
7.3 If not, what is the reason you have not been vaccinated? Mark all that apply.	☐ I am waiting for my appointment ☐ I don't know how or where to get a vaccine ☐ I have tried but have not been able to get an appointment yet ☐ I am waiting for a while before I try to get a vaccine ☐ I don't plan to get the vaccine because of a medical condition I have ☐ I don't plan to get the vaccine because I am afraid of side effects ☐ I don't plan to get the vaccine because I don't trust these vaccines ☐ I don't plan to get the vaccine because I'm not worried about getting COVID-19 ☐ Other
7.3.1 Other (specify):	_____
8. To your knowledge, have you EVER been exposed to another person who has been diagnosed with, or suspected of having, COVID-19 infection?	◯ Yes, someone living with me ◯ Yes, someone outside of my household with whom I have interacted with face-to-face ◯ No, not that I know of
9. Since [date_last_surveyed], have you been tested for COVID-19?	◯ Yes ◯ No ◯ Unsure
9.1 What kind of test(s) did you have? Mark all that apply.	☐ Nasal swab, throat swab, or saliva test (testing for presence of the virus) ☐ Blood test (testing for antibodies/immune response)
9.2 How many times have you been tested?	◯ 1 time ◯ 2 times ◯ 3 or more times ◯ Unsure
9.3 Why did you get tested? Mark all that apply.	☐ I had symptoms that could suggest I had COVID-19 ☐ I was exposed to someone who was known to have COVID-19 ☐ I was traveling ☐ It was part of routine screening (for example, to get medical care or as part of a housing or workplace policy)

9.4 Did any of these tests come back positive for a COVID-19 infection?	◯ Yes ◯ No ◯ Unsure

9.5 Many different symptoms have been associated with COVID-19. Some may be rather short term, others may come and go, and for some people, some symptoms may last a long time. Did you have any of the following symptoms that you believe were associated with COVID-19? If so, how long did you have those symptoms?

9.5.1 Fever	◯ No ◯ Yes
9.5.1.1 How long did you experience fever?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.2 Cough	◯ No ◯ Yes
9.5.2.1 How long did you experience cough?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.3 Headache	◯ No ◯ Yes
9.5.3.1 How long did you experience headache?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.4 Chest pain/tightness	◯ No ◯ Yes
9.5.4.1 How long did you experience chest pain/tightness?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.5 Fast-beating heart, heart pounding (palpitations)	◯ No ◯ Yes
9.5.5.1 How long did you experience fast-beating heart, heart pounding (palpitations)?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.6 Muscle Pain	◯ No ◯ Yes
9.5.6.1 How long did you experience muscle pain?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more

9.5.7 Joint Pain	◯ No ◯ Yes
9.5.7.1 How long did you experience joint pain?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.8 Fatigue	◯ No ◯ Yes
9.5.8.1 How long did you experience fatigue?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.9 Shortness of breath/difficulty breathing	◯ No ◯ Yes
9.5.9.1 How long did you experience shortness of breath/difficulty breathing?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.10 Loss of smell	◯ No ◯ Yes
9.5.10.1 How long did you experience loss of smell?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.11 Loss of taste	◯ No ◯ Yes
9.5.11.1 How long did you experience loss of taste?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.12 Sleep disturbance	◯ No ◯ Yes
9.5.12.1 How long did you experience sleep disturbance?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.13 Memory problems	◯ No ◯ Yes
9.5.13.1 How long did you experience memory problems?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more

9.5.14 Confusion or difficulty thinking or concentrating	◯ No ◯ Yes
9.5.14.1 How long did you experience confusion or difficulty thinking or concentrating?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.15 Brain fog	◯ No ◯ Yes
9.5.15.1 How long did you experience brain fog?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
9.5.16 Malaise--general feeling of illness, discomfort or uneasiness	◯ No ◯ Yes
9.5.16.1 How long did you experience malaise--general feeling of illness, discomfort or uneasiness?	◯ < 2 weeks ◯ 2 weeks to < 8 weeks ◯ 8 weeks to < 6 months ◯ 6 months or more
10. Were you ever hospitalized for COVID-19?	◯ Yes ◯ No ◯ Unsure
10.1 How many nights did you stay in the hospital? If you had multiple hospitalizations, please provide the total number of nights.	◯ 1 night ◯ 2-3 nights ◯ 4-6 nights ◯ 7-13 nights ◯ 14 or more nights ◯ Unsure
10.2 What treatments did you receive? Mark all that apply.	☐ Intravenous fluids ☐ Oxygen through nose prongs or facial mask, but not requiring a ventilator ☐ BiPAP--an non-invasive external breathing support that provides intermittent airway pressure ☐ Invasive ventilation or ventilator (Breathing support through an inserted tube. People are usually asleep for this procedure.) ☐ ECMO-using a machine that puts oxygen in your blood outside of your body, allowing your heart and lungs to rest (People are asleep for this procedure) ☐ Kidney dialysis ☐ Other
10.2.1 Other treatments (specify):	_____
10.3 Did you require treatment in an Intensive Care Unit (ICU)?	◯ Yes ◯ No

10.3.1 How many days?	◯ 1 ◯ 2-3 ◯ 4-6 ◯ 7 or more ◯ Not sure
11. Were you given any of the following medications to treat COVID-19? Mark all that apply.	☐ Remdesivir ☐ Azithromycin ☐ Antibody therapy ☐ Convalescent plasma ☐ Hydroxychloroquine or chloroquine ☐ Dexamethasone or other corticosteroids ☐ Immunosuppressive or biologic agents such as IL-6 or TNF blockers ☐ None of the above ☐ Don't know

SECTION THREE: In this section we ask about your current access to usual health care, and the impact of the COVID-19 pandemic on your health care.

12. From [date_last_surveyed] until now, did you have any health care appointments scheduled?	◯ Yes ◯ No ◯ Unsure
12.1 Other than appointments to get a COVID-19 vaccination, how did you get your health care since [date_last_surveyed]? Mark all that apply.	☐ I had at least one virtual clinic visit by telephone or video ☐ I had at least one in-person clinic or office visit ☐ I was evaluated at an emergency room or hospital ☐ I was hospitalized ☐ None of the above--I did NOT seek care from any healthcare provider or go to the emergency room or hospital
13. Have you had a mammogram during the pandemic?	◯ Yes ◯ No, I chose not to get one because of the COVID-19 pandemic ◯ No, I was not due for a mammogram or did not get one for other reasons
14. Have you been treated for cancer during the pandemic?	◯ Yes ◯ No
14.1 If yes, were you scheduled to have any of the following cancer treatments or care during the pandemic?	
14.1.1 Surgery	◯ No ◯ Yes
14.1.1.1 Did you experience any delays or disruption in getting surgery?	◯ No ◯ Yes
14.1.2 Chemotherapy	◯ No ◯ Yes
14.1.2.1 Did you experience any delays or disruption in getting chemotherapy?	◯ No ◯ Yes
14.1.3 Radiation Therapy	◯ No ◯ Yes
14.1.3.1 Did you experience any delays or disruption in getting radiation therapy?	◯ No ◯ Yes
14.1.4 Immunotherapy	◯ No ◯ Yes
14.1.4.1 Did you experience any delays or disruption in getting immunotherapy?	◯ No ◯ Yes
14.1.5 Monitoring (for example, X-rays, MRI, CT scans)	◯ No ◯ Yes
14.1.5.1 Did you experience any delays or disruption in getting monitoring (for example, X-rays, MRI, CT scans)?	◯ No ◯ Yes

14.1.6 Other therapy requiring infusion	◯ No ◯ Yes
14.1.6.1 Did you experience any delays or disruption in getting any other therapy requiring infusion?	◯ No ◯ Yes
15. In general, how much difficulty have you had getting routine medical care since [date_last_surveyed]?	◯ None ◯ Some ◯ Much ◯ Unable or very difficult
16. Since [date_last_surveyed], have you had any of the following types of care? Mark all that apply.	☐ Regular medical check-up or routine physical exam ☐ Dental appointment ☐ Eye exam or appointment with an eye doctor ☐ Other routine care ☐ None of the above
17. Have you decided not to go to the doctor or hospital when you normally would have gone, to avoid the potential of being exposed to COVID-19?	◯ Yes ◯ No

SECTION FOUR: In this section, we ask about the impact of the COVID-19 pandemic on your health and general well-being and the changes in your life related to the pandemic.

18. In general, how concerned are you about the COVID-19 pandemic?

- ◯ Not at all concerned
- ◯ Somewhat concerned
- ◯ Very concerned

19. Is the COVID-19 pandemic causing you concerns about any of the following? Mark all that apply.

- ☐ My risk of getting a COVID-19 infection
- ☐ The risk of family members or friends getting a COVID-19 infection
- ☐ Getting the health care that I need
- ☐ Getting adequate food
- ☐ Getting enough exercise/physical activity
- ☐ Getting the sleep/rest I need
- ☐ Having adequate housing
- ☐ Having enough money to cover my needs
- ☐ My personal safety
- ☐ The health and safety of my family and friends
- ☐ My financial security
- ☐ The financial security of my family
- ☐ My ability to be with friends and family
- ☐ The nation and the economy more generally
- ☐ None of the above

How often would the following statements apply to you in the past 7 days?					
	Never	Rarely	Sometimes	Often	Always
20. I felt fearful	◯	◯	◯	◯	◯
21. I found it hard to focus on anything other than my anxiety	◯	◯	◯	◯	◯
22. My worries overwhelmed me	◯	◯	◯	◯	◯
23. I felt uneasy	◯	◯	◯	◯	◯

In the past 4 weeks how often have you felt . . .

	Never	Almost never	Sometimes	Fairly often	Very often
24. That you were unable to control the important things in your life?	◯	◯	◯	◯	◯
25. Confident about your ability to handle your personal problems?	◯	◯	◯	◯	◯
26. That things were going your way?	◯	◯	◯	◯	◯
27. That difficulties were piling up so high that you could not overcome them?	◯	◯	◯	◯	◯

28. What steps are you currently taking to reduce your risk of being infected by COVID-19? Mark all that apply.

- ☐ Maintaining a physical distance from people outside my household
- ☐ Wearing a face mask when I am with people outside of my household
- ☐ Avoiding in-person social or religious activities
- ☐ Avoiding or limiting in-person shopping
- ☐ Staying home
- ☐ None of the above

29. How often do you communicate with others who live outside your home in person, by telephone, email or other methods?

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

30. 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

31. What is your current weight?

_____

32. Have you lost more than 10 pounds in the last 2 years without trying?

- ◯ No
- ◯ Yes

33. Have you gained more than 10 pounds in the last 2 years?

- ◯ No
- ◯ Yes

33.1 Were you trying to gain weight?

- ◯ No
- ◯ Yes

34. Thank you for completing this questionnaire. We know this is a challenging time and we appreciate your willingness to continue to help us understand the impact of COVID-19. If there are other aspects that you would like to share, please describe here:

_____

WHIX User

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