



COVID-19 C4R WAVE 2 INTERVIEW WITH PARTICIPANTS

ID NUMBER: [][][][][][][][][]

FORM CODE: C V 2 P

DATE 07/06/2021
Version 1.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: [][]/[][]/[][][][]
Month Day Year

0b. Staff ID: [][][]

0c. Contact Type:

- Annual Follow-Up_A
- Semi-Annual Follow-Ups_S
- Neither_N

Instructions: The date is the day the interview was attempted or completed. Special missing values are allowed for cases where the response "Don't know", "Refused", "Unknown", or "N/A" is not listed as an option.

0d. Has the participant ever reported a COVID-19 diagnosis on form COVP or COVL or is there a record of a COVID-19 hospitalization on the CEL form?

- No₀
- Yes₁

If this form is administered as part of the AFU/sAFU: **"Now I am going to ask a few questions about experiences you may have had with COVID-19."**

If this form is administered separately from the AFU/sAFU: **"We are calling to ask a few questions about experiences you may have had with COVID-19. Responses to this survey will contribute to a better understanding of the COVID-19 infection and the way it affects people."**

0e. Is this a good time to talk?

- No₀ → **GO TO QUESTION 0f**
- Yes₁ → **IF 0d= "Yes", GO TO QUESTION 11; OTHERWISE GO TO QUESTION 1**

0f. Can I call you back at a convenient time to ask these questions?

- No₀ → **SAVE AND CLOSE FORM**
- Yes₁

0g. When would it be convenient to call back?

[][]/[][]/[][][][]
Month Day Year

“Thank you. I will call again.” → **SAVE AND CLOSE FORM**

COVID-19 SELF-REPORT

1. Since our last call on [mm/dd/yyyy], have you had any kind of test for COVID-19? Please include all types of tests that could show current or past infection (e.g., nose, saliva, blood, PCR, antigen, or antibody tests). Please do not report COVID-19 testing done by ARIC.

Yes₁

No₂ → **GO TO QUESTION 7**

Unsure₃ → **GO TO QUESTION 7**

2. What type of test was it? (Check all that apply)

2a. Nose (“nasal”, “nasopharyngeal”) swab

2b. Throat swab

2c. Saliva test

2d. Blood test

2e. Other

2e1. If other, please specify: _____

3. Did you have a positive test that showed you had COVID-19? Please include all types of tests.

Yes₁

No₂ → **GO TO QUESTION 5**

Unsure₃ → **GO TO QUESTION 5**

4. When was it that you first had a test that showed you had COVID-19?

/ / → **GO TO QUESTION 11**
Month Day Year

5. Do you think that you may have had COVID-19 since our last call on [mm/dd/yyyy], even though you had had a negative COVID-19 test?

Yes, definitely₁

Yes, I think so₂

Maybe₃

No₄ → **GO TO QUESTION 30**

6. When was it that you think that you first had COVID-19?

/ / → **GO TO QUESTION 11**
Month Day Year

7. Do you think that you may have had COVID-19 since our last call on [mm/dd/yyyy], even though you did not have a COVID-19 test?

- Yes, definitely₁
- Yes, I think so₂
- Maybe₃
- No₄ → **GO TO QUESTION 30**

8. What were your reason/reasons for not being tested at that time?

- | | No | Yes |
|---|---------------------------------------|---------------------------------------|
| 8a. I didn't know how/where to get tested | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8b. It was hard to get tested (e.g., long lines) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8c. I was afraid to get tested | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8d. I didn't think I needed to be tested | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8e. I was worried about the cost | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8f. I was worried about the consequences of being diagnosed with COVID-19 | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8g. A healthcare provider told me that a test was not necessary | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8h. Other | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 8h1. If other, please specify: _____ | | |

9. When was it that you think that you first had COVID-19?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day		Year						

10. At that time, did you have any of the following?

- | | No | Yes |
|---|---------------------------------------|---------------------------------------|
| 10a. Symptoms of COVID-19 (such as fever, cough, trouble breathing) | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 10b. Contact with someone who had COVID-19? | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 10c. Other | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 10c1. If other, please specify: _____ | | |

COVID-19 RE-INFECTION

“You have reported that you know or think that you have had the COVID-19 infection. The following questions ask about possible re-infections you may have had since that first COVID-19 infection.”

11. Has a healthcare provider ever told you that you may have gotten COVID-19 a second time, or that you have been “re-infected” with COVID-19?

- No₀ → **GO TO QUESTION 16**
- Yes₁

12. When do you know or think that you were first **re-infected** with COVID-19?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

13. At that time, did you have any of the following?

	No	Yes
13a. I had another test that showed that I had COVID-19	<input type="checkbox"/> 0	<input type="checkbox"/> 1
13b. I had symptoms of COVID-19 (fever, cough, trouble breathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1
13c. I had close contact with someone who had COVID-19	<input type="checkbox"/> 0	<input type="checkbox"/> 1
13d. Other	<input type="checkbox"/> 0	<input type="checkbox"/> 1
13d1. If other, please specify: _____		

14. This time, when you were re-infected, how did your symptoms compare to your first infection with COVID-19?

Worse than the first infection₁

About the same as the first infection₂

Better than the first infection₃

I had no symptoms₄

15. Have you had a third COVID-19 infection?

No₀

Yes₁

Do not know₂

COVID-19 HOSPITALIZATION

“I now want to ask you about COVID-19 hospitalizations that you may have had recently.”

16. Since our last call on [mm/dd/yyyy], have you had an overnight stay in a hospital for any illness related to COVID-19?

Yes₁ → **GO TO QUESTION 17**

No₂ → **GO TO QUESTION 23**

Unsure₃ → **GO TO QUESTION 23**

17. How many times have you been admitted to the hospital for COVID-19 or complications resulting from COVID-19? times

18. When was the first time that you were hospitalized for COVID-19 or complications resulting from COVID-19?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

19. Which hospital were you admitted to?

19a. Hospital Name, City, State: ▼

19a1. Specify hospital name, city, and state if not in drop down list:

20. How many nights did you spend in the hospital during your first COVID-19 related hospitalization? nights

21. While in the hospital, did you have any of the following:

21a. Oxygen (by mask or nose)

Yes₁

No₂ → **GO TO QUESTION 21b**

Do not know₃ → **GO TO QUESTION 21b**

21a1. For how many days? days

21b. A breathing tube or ventilator

Yes₁

No₂ → **GO TO QUESTION 21c**

Do not know₃ → **GO TO QUESTION 21c**

21b1. For how many days? days

21c. "Intensive care unit" or ICU monitoring

Yes₁

No₂ → **GO TO QUESTION 21d**

Do not know₃ → **GO TO QUESTION 21d**

21c1. For how many days? days

21d. Dialysis

Yes₁

No₂ → **GO TO QUESTION 22**

Do not know₃ → **GO TO QUESTION 22**

21d1. For how many days? days

22. After this hospitalization, did you?

- Return home₁
- Go to a nursing rehabilitation facility₂
- Go to live with a family member or a friend₃
- Other₄

22a. If other, please specify: _____

COVID-19 SYMPTOMS

23. When you knew or thought that you had COVID-19 did you have any symptoms?

- No₀ → **GO TO QUESTION 25**
- Yes₁
- I do not remember₂ → **GO TO QUESTION 25**

24. Overall, when your COVID-19 symptoms were at their worst, how much did they interfere with (prevent you from going about) your daily activities?

- Not at all₁
- A little bit₂
- Somewhat₃
- Quite a bit₄
- Very much₅
- I do not remember₆

COVID-19 RECOVERY

25. Following your COVID-19 infection, would you say that you are now completely recovered from COVID-19?

- No₀ → **GO TO QUESTION 27a**
- Yes₁
- Unsure₂ → **GO TO QUESTION 27a**

26. How long did it take for you to recover? days

27. Did you experience after the COVID-19 infection any of the following problems?

- | | No | Yes |
|--|---------------------------------------|---------------------------------------|
| 27a. Problems with your memory | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27b. Problems with paying attention | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27c. Problems with your appetite | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27d. Problems with feeling lightheaded | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27e. Trouble sleeping | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27f. Periods of racing heart rate | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |

- | | No | Yes |
|--|---------------------------------------|---------------------------------------|
| 27g. Inability to exercise at your level before COVID | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27h. Inability to return to your usual activities before COVID | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27i. Feeling weak, tired and/or sick 24-48 hours after physical activity | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
| 27j. Other | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ |
- 27j1. If other, please specify: _____

28. How worried are you that the COVID-19 infection is going to have a long-term effect on your health?

- Not at all worried₁
- A little worried₂
- Very worried₃

29. Is there anything else you'd like to share about your COVID-19 recovery experience?

- No₀ → **GO TO QUESTION 30**
- Yes₁

29a. If yes, please specify: _____

COVID-19 VACCINE

30. Have you received a vaccine for COVID-19?

- Yes₁
- No₂ → **GO TO QUESTION 34**
- Unsure₃ → **GO TO QUESTION 34**

31. When were you last vaccinated?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

32. Which vaccine did you receive?

- Moderna₁ → **GO TO QUESTION 33**
- Pfizer₂ → **GO TO QUESTION 33**
- AstraZeneca₃ → **GO TO QUESTION 33**
- Janssen (Johnson and Johnson)₄ → **GO TO QUESTION 33**
- Other₅
- Do not know₆ → **GO TO QUESTION 33**

32a. If other, please specify: _____

33. How many doses did you receive?

- One₁
- One, but plan to get a second one₃
- Two₂

34. Have you received the influenza (“flu”) vaccine at any time since August 2020?

- Yes₁
- No₂
- Unsure₃

35. Have you received the pneumonia vaccine?

- Yes₁
- No₂
- Unsure₃

36. Have you received the shingles vaccine?

- Yes₁
- No₂
- Unsure₃

37. Do you now live alone?

- No₀
- Yes₁
- Prefer not to respond₂

[Do NOT read the following script and do not ask Question 38a through Question 38c if Q0c= “Semi-Annual Follow-Up”]

“In the next part, there will be some questions that we may have already asked you during a previous interview. We would like to ask them again here.”

COVID-19 LONELINESS AND STRESS

“For each of the following questions, please provide the response that describes your life. The response options are often, sometimes, or hardly ever.”

38a. How often do you feel that you lack companionship?

- Often₁
- Sometimes₂
- Hardly ever₃

38b. How often do you feel left out?

- Often₁
- Sometimes₂
- Hardly ever₃

38c. How often do you feel isolated from others?

- Often₁
- Sometimes₂
- Hardly ever₃

39. Here is a statement about how you respond to stressful events. "I tend to bounce back quickly after hard times." Please tell me your level of agreement with that statement.

- Strongly disagree₁
- Disagree₂
- Neutral₃
- Agree₄
- Strongly agree₅

COVID-19 PANDEMIC IMPACT ON BEHAVIOR

"The following questions ask about how your activities may have changed since the start of the COVID-19 pandemic in March 2020."

40. Do you now walk for exercise?

- No₀ → **GO TO QUESTION 41**
- Yes₁

40a. Do you now walk for exercise more frequently, less frequently, or about the same amount?

- More₁
- Less₂
- The same₃

41. Do you now do any vigorous activities, such as washing windows or scrubbing floors?

- No₀ → **GO TO QUESTION 42**
- Yes₁

41a. Do you now engage in vigorous activities more frequently, less frequently, or about the same amount?

- More₁
- Less₂
- The same₃

42. Do you watch shows or movies?

- No₀ → **GO TO QUESTION 43**
 Yes₁

42a. Do you now watch shows or movies more frequently, less frequently, or about the same amount?

- More₁
 Less₂
 The same₃

43. Do you drink alcohol?

- No₀ → **GO TO QUESTION 44**
 Yes₁

43a. Do you now drink alcohol more frequently, less frequently, or about the same amount?

- More₁
 Less₂
 The same₃

43b. On average, how many drinks per week do you now have?

44. Are you now generally eating and snacking more, less or the same amount?

- More₁
 Less₂
 The same₃

[Do NOT ask Question 45 and Question 46 if Question 0c= "Semi-Annual Follow-Up"]

45. Has your weight changed since March 2020?

- Gained weight₁
 Lost weight₂
 No change in weight₃
 Do not know₄

46. Were you trying to change your weight since March 2020?

- No₀
 Yes₁

47. How does your general health compare to before the pandemic?

- It is better₁
 It is worse₂
 It is about the same₃

48. During the pandemic, as compared to the time before it, are you generally sleeping more, less or about the same amount?

More₁

Less₂

The same₃

49. During the past 12 months, have you experienced confusion or memory loss?

No₀ → **SAVE AND CLOSE FORM**

Yes₁

50. Is that happening now more often or is getting worse compared to before March 2020?

No₀

Yes₁

CLOSURE SCRIPT:

“Thank you very much for contributing for the past 30 years to the ARIC study and its mission of ‘Research with Heart’!”