COVID-19 C4R WAVE 3 INTERVIEW WITH PARTICIPANTS

ADMINISTRATIVE INFORMATION

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

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

0c. Contact Type:

☐ Annual Follow-Up

☐ Semi-Annual Follow-Up

☐ Neither

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.

If this form is administered as part of the AFU/sAFU: “This next set of questions will help us learn more about your health during the COVID-19 pandemic. Your response is voluntary.”

If this form is administered separately from the AFU/sAFU: “We are calling to ask about your health during the COVID-19 pandemic. Your response to these questions is voluntary.”

0e. Is this a good time to talk?

☐ No

☐ Yes → GO TO QUESTION 1

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

☐ No → SAVE AND CLOSE FORM

☐ Yes

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

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

“Thank you. I will call again.” → SAVE AND CLOSE FORM
1. Have you ever had COVID-19?
   □ Yes1
   □ No2 → GO TO QUESTION 13
   □ Do not know3 → GO TO QUESTION 13

2. In total, since the beginning of the COVID-19 pandemic in the US (March 2020), how many times do you think you have had COVID-19?
   □ Once (1 infection)1 → GO TO QUESTION 3
   □ Twice (2 infections)2 → GO TO QUESTION 3
   □ Three times (3 infections)3 → GO TO QUESTION 3
   □ More than three times4
   □ Do not know5 → GO TO QUESTION 3

2a. Please enter number of times: □ □

3. Have you ever been hospitalized for COVID-19?
   □ Yes1
   □ No2

“The following questions refer to your most recent COVID-19 infection.”

4. In which year and month did you have the most recent COVID-19 infection? Please estimate the date you think your symptoms started or when you first tested positive, even if you are not sure.

   □ □/□□
   Month Year

5. Did you take a COVID test at that time?
   □ Yes1
   □ No2 → GO TO QUESTION 7

6. Did you have a positive test result? “Positive” means the test showed COVID-19.
   □ Yes1
   □ No2
   □ Do not know3

7. At that time, did you have any COVID-19 symptoms, such as fever, cough, sore throat, or other symptoms?
   □ Yes1
   □ No2 → GO TO QUESTION 10
8. When your COVID-19 symptoms were at their worst, how much did they prevent you from going about your daily activities?

- □ Not at all
- □ A little bit
- □ Somewhat
- □ Quite a bit
- □ Very much

9. Did a doctor or other health care professional prescribe any medications for you to take when you had the most recent COVID-19 infection?

- □ Yes
- □ No
- □ Do not know

Recovery from COVID-19

10. Would you say that you have now completely recovered from COVID-19?

- □ Yes
- □ No → GO TO QUESTION 13

11. How many days did it take for you to recover from your most recent COVID-19 infection? Please estimate even if you are not sure.

- □ □ □ days

12. Do you think that you have ever experienced what has been called “long COVID”, or symptoms related to COVID-19 lasting for at least a month after an infection?

- □ Yes
- □ No
- □ Do not know

Vaccination against COVID-19

13. Have you ever been vaccinated against COVID-19?

- □ Yes
- □ No → GO TO QUESTION 16
- □ Do not know → GO TO QUESTION 16
14. In total, how many COVID-19 vaccine shots have you received?

☐ 1 → GO TO QUESTION 15
☐ 2 → GO TO QUESTION 15
☐ 3 → GO TO QUESTION 15
☐ 4 → GO TO QUESTION 15
☐ 5 or more
☐ Do not know → GO TO QUESTION 15

14a. Please specify number of COVID-19 vaccine shots received: [ ] [ ]

15. In which year and month did you have the most recent COVID-19 vaccine? Please estimate even if you are not sure.

[ ] [ ]/

Global Health

16. In the past 7 days, what has been your level of fatigue, on average?

☐ None
☐ Mild
☐ Moderate
☐ Severe
☐ Very severe

17. During the past 7 days, how would you rate your pain on average? Please provide a number from 1 (no pain) to 10 (worst imaginable pain).

☐ ☐

18. In general, how would you rate your mental health, including your mood and your ability to think clearly?

☐ Excellent
☐ Very good
☐ Good
☐ Poor
☐ Very poor
Symptom Survey

19. During the past month, have you felt faint or dizzy? Another way of saying this is that you had difficulty thinking soon after standing up from a sitting or lying position.
   - Yes
   - No
   - Do not know

20. During the past month, have you experienced any of the following symptoms: palpitations, racing heart, arrhythmia, or skipped beats?
   - Yes
   - No
   - Do not know

CLOSURE SCRIPT:

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