COVID-19 C4R WAVE 3 INTERVIEW WITH PROXY OF LIVING PARTICIPANTS

ADMINISTRATIVE INFORMATION

0a. Completion Date: [ ]/[ ]/[ ]

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 last set of questions is about COVID-19 infections.”

If this form is administered separately from the AFU/sAFU: “We are calling to ask a few questions about experiences [name] may have recently had with COVID-19. Responses to this survey will contribute to a better understanding of the long-term effects of the COVID-19 infection.”

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?

[ ]/[ ]/[ ]

“Thank you. I will call again.” → SAVE AND CLOSE FORM
1. Has [name] ever had COVID-19?
   - Yes
   - No
   - Do not know
   - 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 [name] has had COVID-19? Please estimate even if you are not sure.
   - Once (1 infection)
   - Twice (2 infections)
   - Three times (3 infections)
   - More than three times
   - Do not know
   - Go to Question 3

   2a. Please enter number of times:

3. Has [name] ever been hospitalized for COVID-19?
   - Yes
   - No

“The following questions refer to [name]’s most recent COVID-19 infection.”

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

   Month
   Year

5. Did [name] take a COVID test at that time?
   - Yes
   - No
   - Go to Question 7

6. Did [name] have a positive test result? “Positive” means the test showed COVID-19.
   - Yes
   - No
   - Do not know

7. At that time, did [name] have any COVID-19 symptoms, such as fever, cough, sore throat, or other symptoms?
   - Yes
   - No
   - Go to Question 10
8. When [name]’s COVID-19 symptoms were at their worst, how much did they prevent [name] from going about his/her 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 [name] to take when he/she had the most recent COVID-19 infection?

- [ ] Yes
- [ ] No
- [ ] Do not know

**Recovery from COVID-19**

10. Would you say that [name] has now completely recovered from COVID-19?

- [ ] Yes
- [ ] No → GO TO QUESTION 13

11. How many days did it take for [name] to recover from his/her most recent COVID-19 infection? Please estimate even if you are not sure.

- [ ] [ ] [ ] days

12. Do you think that [name] has 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. Has [name] 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 has [name] 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 [name] have the most recent COVID-19 vaccine? Please estimate even if you are not sure.

Month/Year

Global Health

16. In the past 7 days, what has been [name]'s level of fatigue, on average?

☐ None
☐ Mild
☐ Moderate
☐ Severe
☐ Very severe

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

□ □

18. In general, how would you rate [name]'s mental health, including his/her mood and his/her ability to think clearly?

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

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

20. During the past month, has [name] 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’!”