# **COVID** Symptom Tracker

List of question

**Q (text entry):** Your email

**Q (text entry):** Your name

**Q (text entry):** Phone number

**Q (multi-select):** Are you already a participant in a research study at?
1. Mass General Brigham

    a. Nurses' Health Studies

    b. COVID-19 Studies

2. Stanford

    a. Stanford Diabetes Registry

    b. Stanford WELL Registry
3. Other medical center or university: Please name the study, if you know it .

**Q (select one):** Are you a healthcare professional?
1. No
2. Yes, currently treat patients
3. Yes, do not currently treat patients

*If "yes" show*

**Q (multi-select):** Since the COVID-19 epidemic began, have you physically worked in? (check all that apply)
1. Hospital inpatient
2. Hospital outpatient
3. Clinic outside a hospital
4. Nursing home or group care facility
5. Home health
6. School clinic
7.Other health care facility

**Q (select one):** Have you EVER interacted in person with patients with documented or presumed COVID-19 infection? (check all that apply)
1. No
2. Yes, documented COVID-19 cases
3. Yes, presumed COVID-19 cases
4. Not that I know of

**Q (select one):** Since the COVID-19 epidemic began, have you used personal protective equipment (PPE) at work? *Depending on your specific work requirements, PPE might include gloves, masks, face shields, etc
1. Always
2. Sometimes
3.Never

*If "always" show:*

**Q (chose one):** Choose one of the option?
1. I have had all the PPE I need for work
2. I had to reuse PPE because of shortage

*If "sometime" show:*

**Q (chose one):** (Check all that apply)
1. I haven't always needed to use PPE, but have had enough when I did
2. I would have used PPE all the time, but I haven't had enough
3. I've had to reuse PPE because of shortage

*If "never" show:*

**Q (chose one):** Choose one of the options
1. I haven't needed PPE
2. I needed PPE, but it was not available

**Q (text entry):** What year were you born?

**Q (chose one):** What sex were you assigned at birth?
1. Male
2. Female
3. Prefer not to say

**Q (text entry):** Your height?

**Q (text entry):** Your weight?

**Q (text entry):** Your zipcode?

**Q (multi-select):** Have you EVER been exposed to someone with documented or presumed COVID-19 infection (such as co-workers, family members, or others)? Please check all that apply.
1. Yes, documented COVID-19 case
2. Yes, presumed COVID-19 cases
3. Not that I know of

**Q (select one):** In general, do you have any health problems that require you to stay at home?
1. No
2. Yes

**Q (select one):** Do you need someone to help you on a regular basis?
1. No
2. Yes

**Q (select one):** If you need help, can you count on someone close to you ?
1. No
2. Yes

**Q (select one):** Do you regularly use a cane, walker or wheelchair to get about?
1. No
2. Yes

**Q (select one):** In general, do you have any health problems that require you to limit your activities?
1. No
2. Yes

*If answered "female" previously show:*

**Q (select one):** Are you pregnant?
1. No
2. Yes

**Q (select one):** Do you have heart disease?
1. No
2. Yes

**Q (select one):** Do you have diabetes?
1. No
2. Yes

**Q (select one):** Do you have lung disease or asthma?
1. No
2. Yes

**Q (select one):** Do you smoke?
1. Yes
2. Not currently, but in the past
3. Never

*If "Not currently, but in the past" show:*

**Q (text entry):** How many years since you last smoked?

**Q (select one):** Do you have kidney disease?
1. No
2. Yes

**Q (select one):** Are you living with cancer?
1.No
2. Yes

**Q (select one):** Are you on chemotherapy or immunotherapy for cancer?
1.No
2. Yes

Q (select one): Are you participating in a clinical trial?

1. No
2. Yes

Q (If yes) Where are you receiving treatment? Free text

Q (If yes) Do you know the NCT identifier for the trial?

1. No
    a. If no, provide name of the doctor you see for the trial.
2. Yes (Provide NCT number)

**Q (select one):** Do you regularly take immunosuppressant medications (including steroids, methotrexate, biologic agents)?
1. No
2. Yes

**Q (select one):** Do you regularly take aspirin (baby aspirin or standard dose)?
1. No
2. Yes

**Q (select one):** Do you regularly take NSAIDs like ibuprofen, nurofen, diclofenac, naproxen?
1. No
2. Yes

**Q (select one):** Are you regularly taking blood pressure medications ending in -pril, such as enalapril, lisinopril, captopril, ramipril) ?
1. No
2. Yes

**Q (select one):** Are you regularly taking blood pressure medications ending in -sartan, such as losartan, valsartan, irbesartan?
1. No
2. Yes

**Q (select one):** Do you think you have already had COVID-19, but were not tested)?
1. No
2. Yes

*If "Yes" show:*

**Q (select one):** Did you have the classic symptoms (high fever and persistent cough) for several days?
1. No
2. Yes

**Q (number entry):** How many days ago did your symptoms start?

**Q (select one):** Have you had a test for COVID-19?
1. No
2. Yes

*If "Yes" show:*

**Q (select one):** Did you test positive for COVID-19?
1. No
2. Yes
3. Waiting for results

**Q (select one):** How do you feel physically right now?
1. I feel physically normal
2. I'm not feeling quite right

**Q (select one):** Do you have a fever?
1. No
2. Yes

**Q (number entry):** If you are able to measure it, what is your temperature?

**Q (select one):** Do you have a persistent cough (coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours)?
1. No
2.Yes

**Q (select one):** Are you experiencing unusual fatigue?
1. No
2. Mild fatigue
3. Severe fatigue - I struggle to get out of bed

**Q (select one):** Do you have a headache?
1. No
2. Yes

**Q (select one):** Are you experiencing unusual shortness of breath?
1. No
2. Yes. Mild symptoms - slight shortness of breath during ordinary activity.
3. Yes. Significant symptoms - breathing is comfortable only at rest.
4. Yes. Severe symptoms - breathing is difficult even at rest.

**Q (select one):** Do you have a sore throat?
1.No
2.Yes

**Q (select one):** Do you have loss of smell/taste?
1. No

2. Yes

**Q (select one):** Do you have an unusually hoarse voice?
1. No
2.Yes

**Q (select one):** Are you feeling unusual chest pain or tightness in your chest?
1.No
2.Yes

**Q (select one):** Do you have unusual abdominal pain?
1.No
2.Yes

**Q (select one):** Are you experiencing diarrhea?
1.No
2.Yes

Q (select one): Are you experiencing nausea?

1. No
2. Yes

**Q (select one):** Have you been skipping meals?
1.No
2. Yes

**Q (long text entry):** Any there other important symptoms you want to share with us?

**Q (select one):** Where are you right now?

1. I'm at home. I have not been to the clinic or hospital for suspected COVID symptoms
2. I am in the clinic or hospital with suspected COVID symptoms
3. I am back from the clinic or hospital, I'd like to tell you about my treatment
4. I am back from the clinic or hospital, I've already told you about my treatment

*If "I am in the hospital with suspected COVID symptoms" OR "I am back from the hospital, I'd like to tell you about my treatment" show:*

**Q (select one):** What treatment are you (did you) receiving right now?

1. None

2. Oxygen and fluids* (*Breathing support through an oxygen mask, no pressure applied)
3. Non-invasive ventilation* (*Breathing support through an oxygen mask, which pushes oxygen into your lungs)
4. Invasive ventilation* (*Breathing support through an inserted tube. People are usually asleep for this procedure)
5. Other

## Additional daily questions for healthcare workers, who currently treats patients shown on repeat use.

**Q (select one):** In the last day, did you treat patients in person with documented or presumed COVID-19 infection? Please check all that apply.

1. Yes, documented COVID-19 cases
2. Yes, presumed COVID-19 cases
3. Not that I know of

**Q (select one):** In the last day, did you use personal protective equipment (PPE) at work? *Depending on your specific work requirements, PPE might include gloves, masks, face shields, etc.

1. All the time

2. Some of the time
3. None of the time

*If "All of the time" show:*

**Q (select one):** Choose one of the options:

1. I had all the PPE I need for work
2. I had to reuse PPE because of a shortage

*If "Some of the time" show:*

**Q (select one):** Choose one of the options:

1. I didn’t need to use PPE all the time, but had enough when I did
2. I would have used PPE all the time, but I didn’t have enough
3. I had to reuse PPE because of a shortage

*If "None of the time " show:*

**Q (select one):** Choose one of the options:

1. I didn’t need PPE
2. I needed PPE, but it was not available