*The questionnaire below was distributed as a web-only questionnaire, with skip patterns based on bracketed instructions.*

Date of Birth: MM/DD/YYYY

Today's date: MM/DD/YYYY

| **1.** Did you receive an influenza (flu) shot in 2019 or 2020? | |
|---|---|
| Yes | |
| No | |

| 2. Did you have health insurance in 2019 or 2020? *Please mark all that apply* | |
|---|---|
| Medicare Part A | [if yes] still have? Y/N |
| Medicare Part B | [if yes] still have? Y/N |
| Medicaid | [if yes] still have? Y/N |
| Other insurance (e.g. employer-based) | [if yes] still have? Y/N |
| No insurance | [if yes] still have? Y/N |

| 3. Are you living alone now? | |
|---|---|
| Yes | |
| No | |
| a. [If no] Who are you living with now? *Please mark all that apply* | |
| With partner/spouse | |
| With children | |
| With parents | |
| With other relatives | |
| With friends or roommates | |
| | |
| b. How many people in all do you live with? | |

| 4. Do you know or believe that you have had COVID-19? | | |
|---|---|---|
| Yes | | |
| No | | |
| Uncertain | | |
| | | |
| a. Were you diagnosed by a doctor or nurse? | | |
| Yes | | |
| No | | |
| b. Not seen by a doctor or nurse, but had COVID-19 symptoms? | | |
| Yes | | |
| No | | |

| | | |
|---|---|---|
| c. Have you ever had a COVID-19 test? | | |
| Yes | | |
| No | | |
| Uncertain | | |
| d. Have you ever had a positive COVID -19 test? | | |
| Yes | | |
| No | | |
| Uncertain | | |
| e. What type of test have you had? *Please mark all that apply* | | |
| Nasal swab | | [if yes] Positive? (Y/N/Uncertain) |
| Blood test | | [if yes] Positive? (Y/N/Uncertain) |
| Chest X-ray | | [if yes] Positive? (Y/N/Uncertain) |
| CT scan of the lung | | [if yes] Positive? (Y/N/Uncertain) |
| f. Other test. Please specify: | | [if yes] Positive? (Y/N/Uncertain) |
| _____ | | |
| g. Have you ever had an overnight stay in a hospital for suspected or diagnosed COVID-19? | | |
| Yes | | |
| No | | |
| h. [If yes,] How many nights were you in the hospital? | | |
| Number:_____ | | |
| i. [If yes,] Did you require any of the following treatments? *Please mark all that apply* | | |
| Oxygen by nasal canula (in your nose)? | | |
| Oxygen by face mask? | | |
| "Intensive care unit" or ICU monitoring? | | |
| A breathing tube or ventilator? | | |
| "ECMO" (extracorporeal membrane oxygenation) treatment? | | |
| j. Where did you go after being discharged from the hospital? *Please mark all that apply* | | |
| Home | | |
| Nursing home/rehab | | |
| Other (Please specify) | | |

| | | |
|---|---|---|
| k. If you know or believe that you had COVID-19, have you recovered your usual state of health? | | |
| Yes | | |
| No | | |
| l. [If yes,] How long did it take to recover? | | |
| Days (less than 7) | | |
| Weeks (less than 4) | | |
| Months (1 or more) | | |
| m. [If no,] How long has it been since you became ill? | | |
| Days (less than 7) | | |
| Weeks (less than 4) | | |
| Months (1 or more) | | |

| | | |
|---|---|---|
| 5. If you know or believe that you had COVID-19, were you living alone **at the time you became infected**? | | |
| Yes | | |
| No | | |
| c. [If no] Who were you living with **at the time you became infected?** *Please mark all that apply* | | |
| With partner/spouse | | |
| With children | | |
| With parents | | |
| With other relatives | | |
| With friends or roommates | | |
| | | |
| d. How many people in all did you live with? | | |
| 6. If you know or believe that you have had COVID-19, how do you think you became infected? *Please mark all that apply* | | |
| Household member | | |
| At work | | |
| On public transportation | | |
| Social activity (e.g., party) | | |
| Do not know/Unsure | | |
| Other (please specify): | | |

| | |
|---|---|
| 7. If you know or believe that you had COVID-19, did you develop any of the following conditions **afterwards**? *Please mark all that apply* | |
| Heart attack | |
| Stroke | |
| Coronary bypass surgery | |
| Angina | |
| Congestive heart failure | |
| Atrial fibrillation | |
| Blood clot in leg or lungs | |
| Angioplasty or stent | |
| Other serious illness (please specify):<br>_____<br>_____<br>_____ | |
| No serious illness(es) | |

| |
|---|
| 8. If you know or believe that you had COVID-19, did you develop dermatitis or a rash **afterwards**? |

| | | |
|---|---|---|
| **Yes** | | |
| **No** | | |
| [If yes,] How soon **after** the COVID-19 diagnosis did the rash develop? | | |
| Days (less than 7) | | |
| Weeks (less than 4) | | |
| Months (1 or more) | | |
| During the illness | | |
| [If yes,] Where was the rash located on your body? *Please mark all that apply* | | |
| Face/head/neck | | |
| Arms/hands | | |
| Legs/feet | | |
| Chest/stomach | | |
| Back | | |
| [If yes,] How would you describe the rash? *Please mark all that apply* | | |
| Patchy | | |
| Vesicles | | |
| Red | | |
| Itchy | | |
| Extensive | | |
| Scattered | | |
| [If yes], Were you treated for the rash with a medication? | Yes | No |
| [If yes] Name of medication: _____ _____ | | |

| 9. If you know or believe that you had COVID-19: | | | | | | |
|---|---|---|---|---|---|---|
| Which of the following medications were you taking **at the time of infection/diagnosis**? *Please mark all that apply* | | How long have you been taking the medication? | | | | |
| | | Days (less than 7) | Weeks (less than 4) | Months (less than 12) | Years (1 or more) | |
| Aspirin | | | | | | |
| Number of tablets/day____<br>Number of days/week____ | | | | | | |
| Acetaminophen (Tylenol, Panadol) | | | | | | |
| Ibuprofen (Motrin) | | | | | | |
| Naproxen (Aleve) | | | | | | |
| Pills to lower cholesterol | | | | | | |
| Medication name: _____ | | | | | | |
| Insulin pump or injection for diabetes | | | | | | |
| Metformin of diabetes | | | | | | |
| Other pills for diabetes | | | | | | |
| Diuretics (water pills) for high blood pressure or other reasons | | | | | | |
| ACE inhibitors (e.g., Captopril, Lisinopril, Prinivil) for high blood pressure | | | | | | |
| Angiotensin receptor blockers (ARBs) (e.g., Losartan, Cozaar) for high blood pressure | | | | | | |
| Steroids (e.g., Prednisone) | | | | | | |
| Inhalers for asthma | | | | | | |
| Multivitamins | | | | | | |
| Vitamin D | | | | | | |
| Medication for depression (e.g., Cymbalta, Zoloft, Prozac) | | | | | | |
| | | | | | | |
| Please list any other medications you were taking at the time of COVID-19 diagnosis: | | | | | | |
| | | | | | | |
| | | | | | | |

| | Yes | No |
|---|---|---|
| **Q10.** Do you have peripheral neuropathy? | | |
| | | |
| | | |
| **Q11.** Do you have hay fever involving your nose or eyes **most years**? | | |

**12.** How many people do you know who have had COVID-19? ___

| 13. How has the Coronavirus pandemic affected your life? | | |
|---|---|---|
| | **Yes** | **No** |
| I was infected. | | |
| A family member or friend was infected. | | |
| A family member or friend died of COVID-19 | | |
| I was laid off from my job or had to close my business. | | |
| I had to continue work at my workplace even though it was unsafe. | | |
| I worked from home. | | |
| I provided direct care to people with COVID-19 (I'm a health care provider). | | |
| I provided direct care to people with COVID-19 (I'm a caregiver to a family member). | | |
| I had a child (children) at home who could not go to school. | | |
| I tried to teach my child (children) at home. | | |
| There was an increase in difficulty at home with other adults. | | |
| I was separated from seeing family members. | | |
| I was unable to see family/friends in critical condition (hospitalized). | | |
| I was unable to go to church/religious services. | | |
| I was unable to get enough food. | | |
| I was unable to pay important bills such as rent. | | |
| I became homeless. | | |
| I was unable to exercise enough. | | |
| I exercised more (e.g., virtual group(s) or on my own). | | |
| My food intake was less healthy. | | |
| My food intake was more healthy. | | |
| I spent more time sitting. | | |
| I got less medical care than usual (e.g., routine or preventive care appointments). | | |
| Important medical procedures were cancelled (e.g., surgery) | | |
| I had difficulty getting needed medical care (e.g., dialysis). | | |
| I had difficulty getting needed mental health care. | | |
| I felt isolated. | | |
| I felt anxious. | | |
| I felt depressed. | | |

**Comments:** _____ _____
_____
_____
_____