Overview

Dr. Elizabeth Oelsner, MD, MPH, a pulmonologist and MESA investigator at Columbia University, adapted the widely used FLU-PRO questionnaire, which asks about flu symptoms and severity, to capture diagnoses, symptoms, and medical interventions related to COVID-19.

The MESA COVID-19 questionnaire is a telephone-administered interview estimated to take 5 minutes (if the participant has not been diagnosed with COVID-19 and has no symptoms) to 30 minutes to administer. It is designed to collect data on the diagnosis, symptoms, and medical interventions associated with the newly identified disease called COVID-19 caused by infection with the SARS-CoV-2 virus.

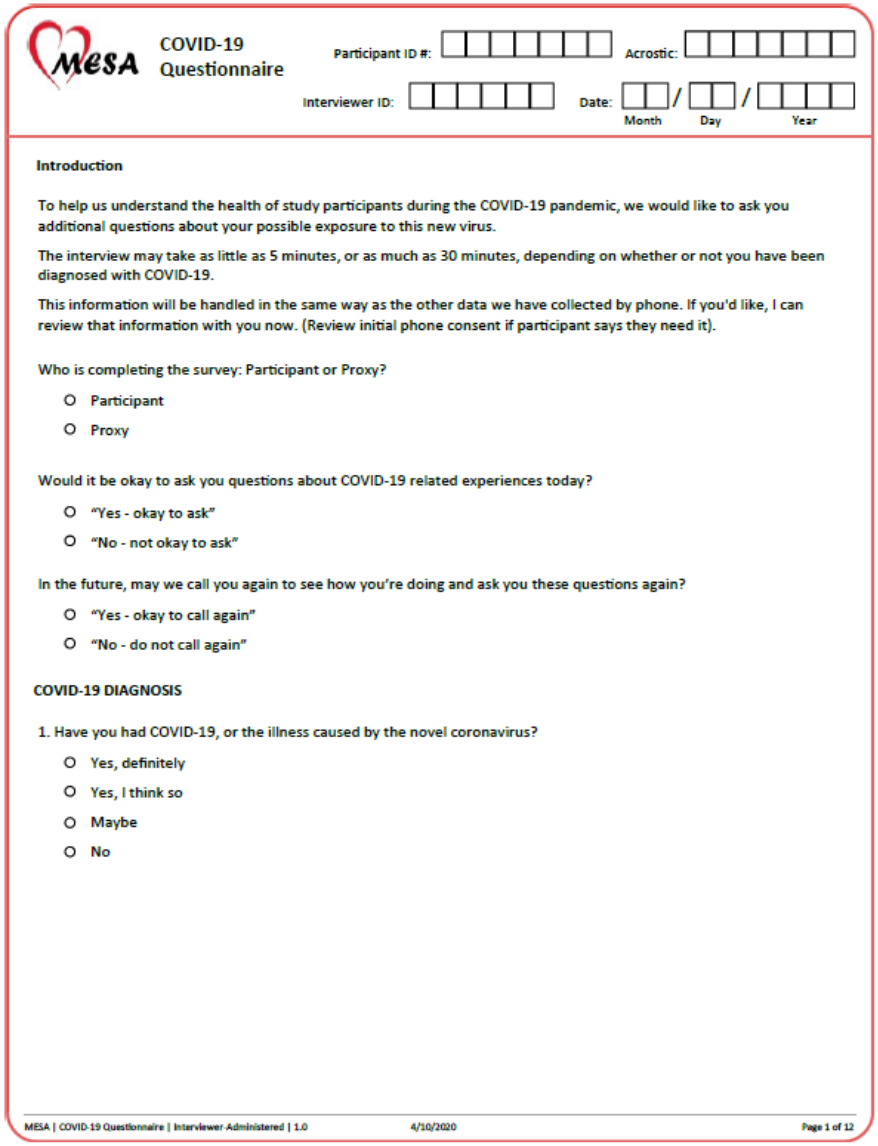
Self-report of diagnoses, symptoms, and medical interventions will be collected during the interview. Any associated medical records will be collected, if required, after the interview.

Additional details for the interview questions are provided below. Clarifications and additional instructions are *italicized*.

1. Have you had COVID-19, or the illness caused by the novel coronavirus?

○ Yes, definitely	→ *have a positive test result or confirmation of HCP*
○ Yes, I think so	→ *believe they have/had it but have not been tested or have not yet received test results, or HCP was unsure*
○ Maybe	→ *aren't sure, any circumstance*
○ No	→ *have a negative test result or have no reason to believe they have had it*

All responses continue to question #2.



COVID-19 Questionnaire

Participant ID #: Acrostic:

Interviewer ID: Date: Month / Day / Year

Introduction

To help us understand the health of study participants during the COVID-19 pandemic, we would like to ask you additional questions about your possible exposure to this new virus.

The interview may take as little as 5 minutes, or as much as 30 minutes, depending on whether or not you have been diagnosed with COVID-19.

This information will be handled in the same way as the other data we have collected by phone. If you'd like, I can review that information with you now. (Review initial phone consent if participant says they need it).

Who is completing the survey: Participant or Proxy?

- O Participant
- O Proxy

Would it be okay to ask you questions about COVID-19 related experiences today?

- O "Yes - okay to ask"
- O "No - not okay to ask"

In the future, may we call you again to see how you're doing and ask you these questions again?

- O "Yes - okay to call again"
- O "No - do not call again"

COVID-19 DIAGNOSIS

1. Have you had COVID-19, or the illness caused by the novel coronavirus?

- O Yes, definitely
- O Yes, I think so
- O Maybe
- O No

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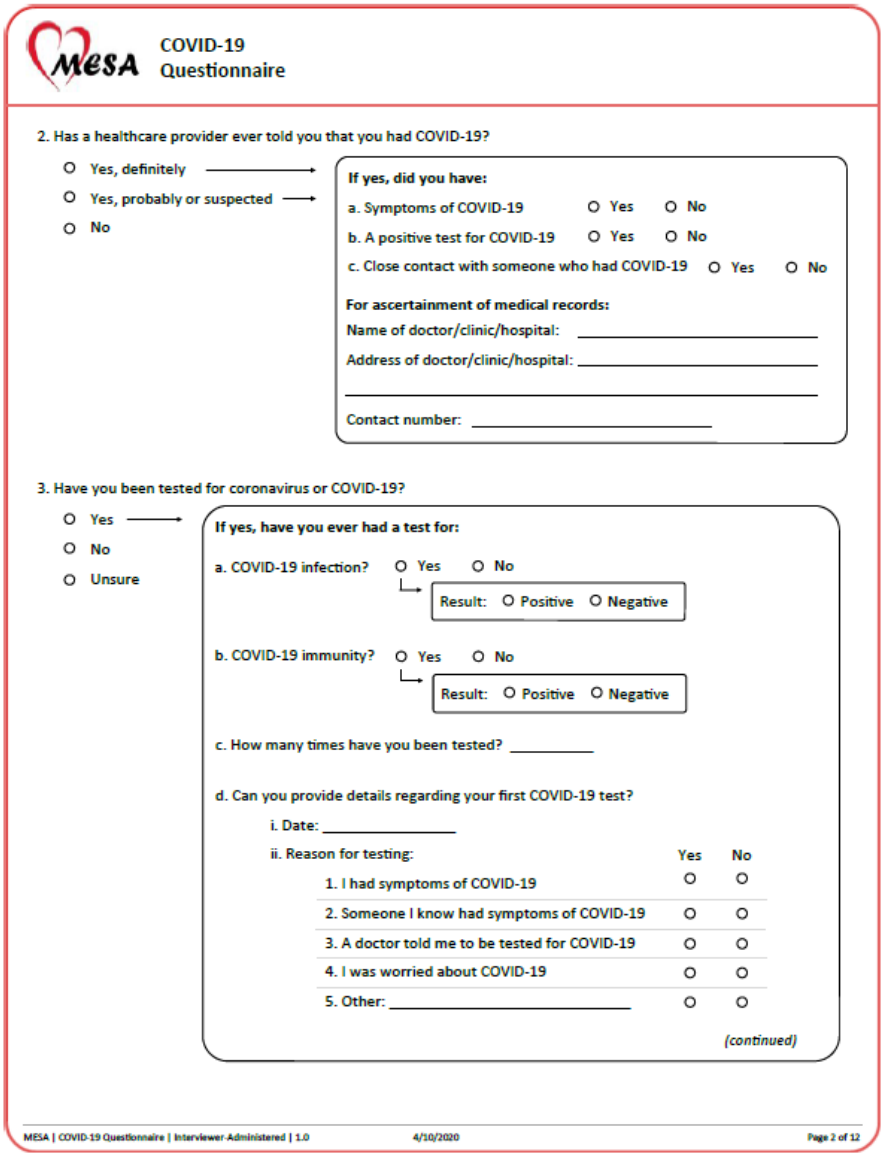
2. Has a healthcare provider ever told you that you had COVID-19?

○	Yes, definitely	*Participant is certain they have been told they have/had COVID-19* → Proceed to box below
○	Yes, I think so	*Participant is not completely sure they have been told they have/had COVID-19* → *Proceed to box below*
○	No	→ *Proceed to question 3*

If answered "Yes, definitely" or "Yes, I think so" to #2:

Item	**Explanation**
Ask all questions in this box	
Did you have:	
a) Symptoms of COVID-19 ○ Yes ○ No	*a) One or more of: cough, sore throat, fever, difficulty breathing, etc.*
b) Close contact with someone who had COVID-19 ○ Yes ○ No	*b)"close contact": within 6 ft or received goods from a person with COVID-19 as confirmed by a test or HCP*
c) A positive test for COVID-19 ○ Yes ○ No	*c) "test": laboratory test like nasal swab or serum (blood)*
For ascertainment of medical records: Name of doctor/clinic/hospital *where test or diagnosis was obtained*: _____ Address of doctor/clinic/hospital: _____	*Ask for contact information of doctor/clinic/hospital <u>where COVID-19 test was obtained</u>*



COVID-19 Questionnaire

2. Has a healthcare provider ever told you that you had COVID-19?

- O Yes, definitely →
- O Yes, probably or suspected →
- O No

If yes, did you have:

a. Symptoms of COVID-19 O Yes O No

b. A positive test for COVID-19 O Yes O No

c. Close contact with someone who had COVID-19 O Yes O No

For ascertainment of medical records:

Name of doctor/clinic/hospital: _____

Address of doctor/clinic/hospital: _____

Contact number: _____

3. Have you been tested for coronavirus or COVID-19?

- O Yes →
- O No
- O Unsure

If yes, have you ever had a test for:

a. COVID-19 infection? O Yes O No → Result: O Positive O Negative

b. COVID-19 immunity? O Yes O No → Result: O Positive O Negative

c. How many times have you been tested? _____

d. Can you provide details regarding your first COVID-19 test?

i. Date: _____

ii. Reason for testing:

	Yes	No
1. I had symptoms of COVID-19	O	O
2. Someone I know had symptoms of COVID-19	O	O
3. A doctor told me to be tested for COVID-19	O	O
4. I was worried about COVID-19	O	O
5. Other: _____	O	O

(continued)

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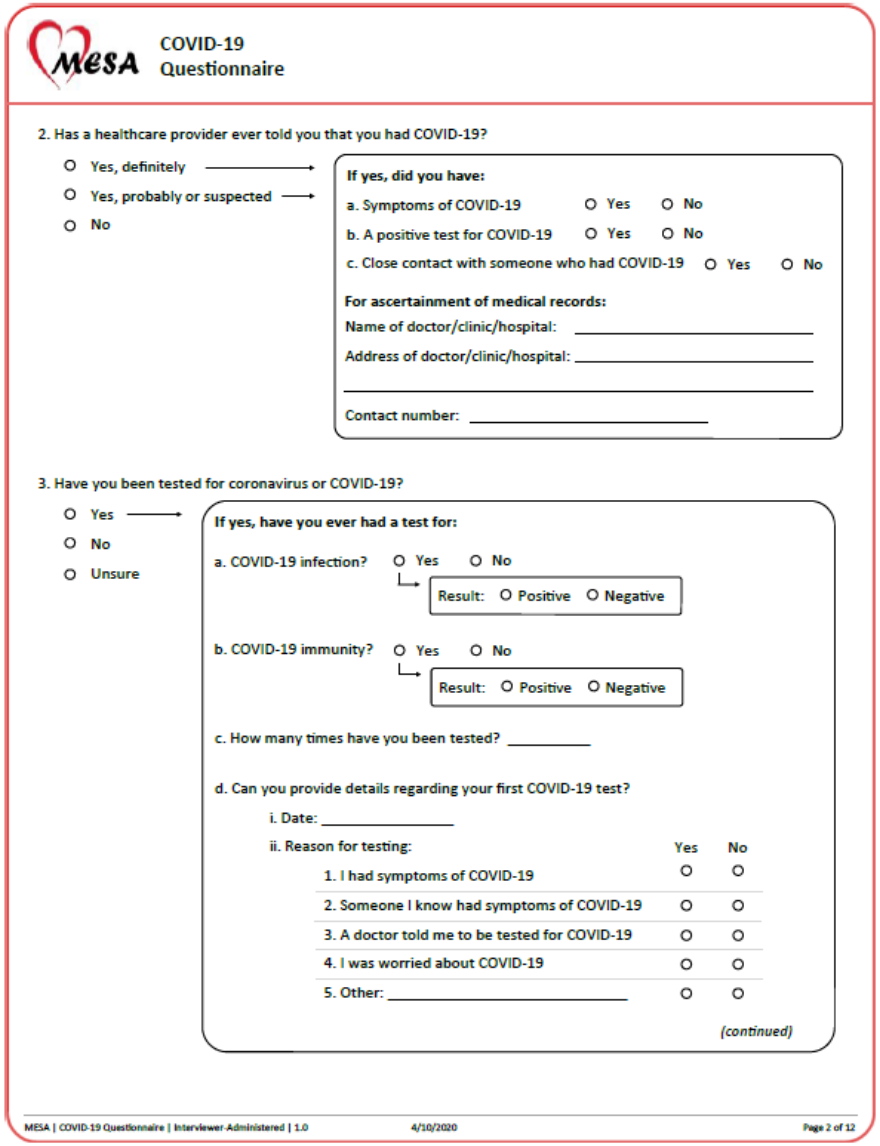
(page 2 continued)

3. Have you been tested for coronavirus or COVID-19?
   - a. Yes — Had a nasal, saliva, or serum test → Proceed to box below
   - b. No → Proceed to question 4
   - c. Unsure — Unsure of the purpose of any tests received or doesn't recall. → Proceed to question 4

If answered "Yes" to #3:

Item	Explanation
Ask all questions in this box	
Have you ever had a test for:	
a. COVID-19 infection?	*a. This is a test for the virus*
b. COVID-19 immunity?	*b. This is a test for and antibody to the virus*
c. How many times have you been tested?	*Count saliva, nasal, serum separately.*
d. Can you provide details regarding your first COVID-19 test?	
i. Date	*Date test performed.*
ii. Reason for testing:	*ii. Response required for each item 1-4.*

(page 2 continued)



COVID-19 Questionnaire

2. Has a healthcare provider ever told you that you had COVID-19?

- O Yes, definitely → **If yes, did you have:**
  - a. Symptoms of COVID-19 O Yes O No
  - b. A positive test for COVID-19 O Yes O No
  - c. Close contact with someone who had COVID-19 O Yes O No

  For ascertainment of medical records:
  Name of doctor/clinic/hospital: _____
  Address of doctor/clinic/hospital: _____
  _____
  Contact number: _____
- O Yes, probably or suspected →
- O No

3. Have you been tested for coronavirus or COVID-19?

- O Yes → **If yes, have you ever had a test for:**
  - a. COVID-19 infection? O Yes O No → Result: O Positive O Negative
  - b. COVID-19 immunity? O Yes O No → Result: O Positive O Negative
  - c. How many times have you been tested? _____
  - d. Can you provide details regarding your first COVID-19 test?
    - i. Date: _____
    - ii. Reason for testing:

	Yes	No
1. I had symptoms of COVID-19	O	O
2. Someone I know had symptoms of COVID-19	O	O
3. A doctor told me to be tested for COVID-19	O	O
4. I was worried about COVID-19	O	O
5. Other: _____	O	O

(continued)
- O No
- O Unsure

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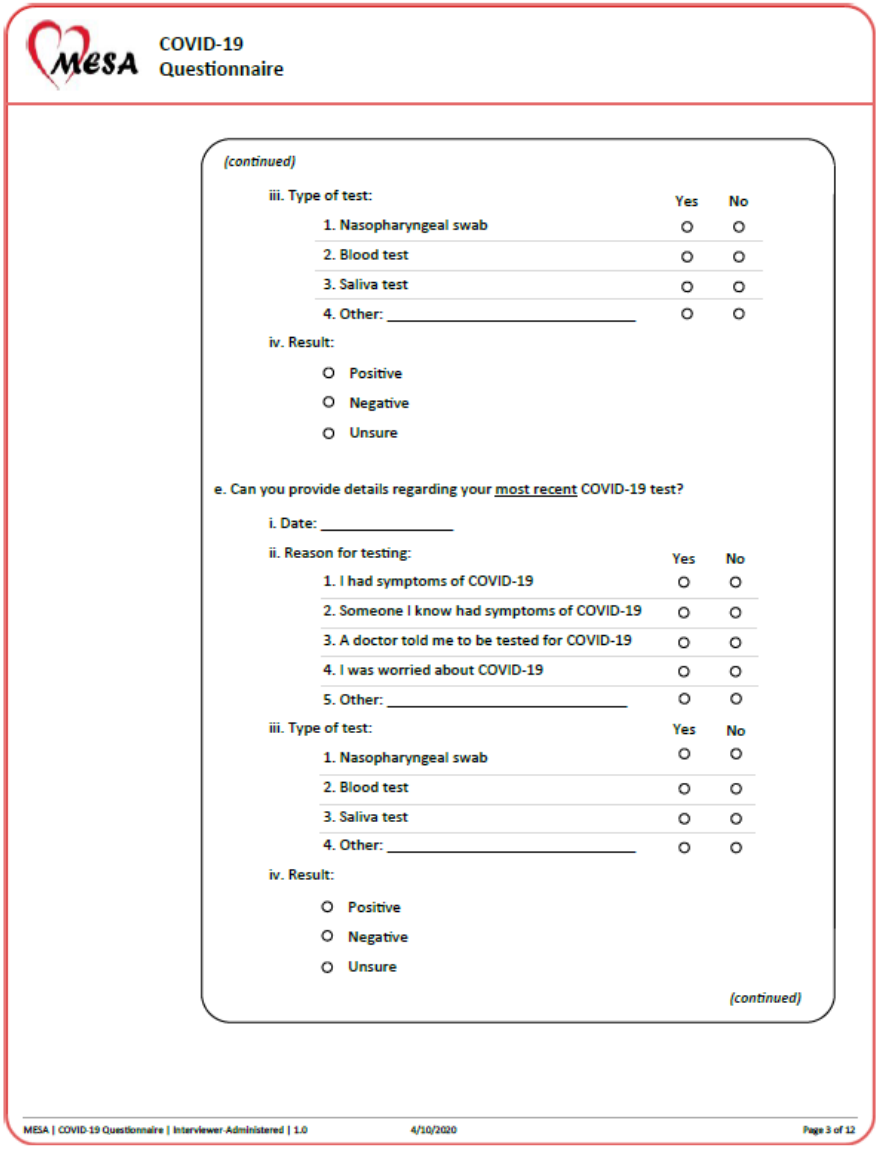
Item	Explanation
iii. Type of test	*iii. Response required for each item 1-3.*
iv. Result	*iv. "Unsure" includes if test result is pending or inconclusive.*
e. Can you provide details regarding your most recent COVID-19 test?	*e. If participant has only had one test, skip item e and proceed to item f (this happens automatically in REDCap).*



COVID-19 Questionnaire

(continued)

iii. Type of test:

	Yes	No
1. Nasopharyngeal swab	O	O
2. Blood test	O	O
3. Saliva test	O	O
4. Other: _____	O	O

iv. Result:

- O Positive
- O Negative
- O Unsure

e. Can you provide details regarding your most recent COVID-19 test?

i. Date: _____

ii. Reason for testing:

	Yes	No
1. I had symptoms of COVID-19	O	O
2. Someone I know had symptoms of COVID-19	O	O
3. A doctor told me to be tested for COVID-19	O	O
4. I was worried about COVID-19	O	O
5. Other: _____	O	O

iii. Type of test:

	Yes	No
1. Nasopharyngeal swab	O	O
2. Blood test	O	O
3. Saliva test	O	O
4. Other: _____	O	O

iv. Result:

- O Positive
- O Negative
- O Unsure

(continued)

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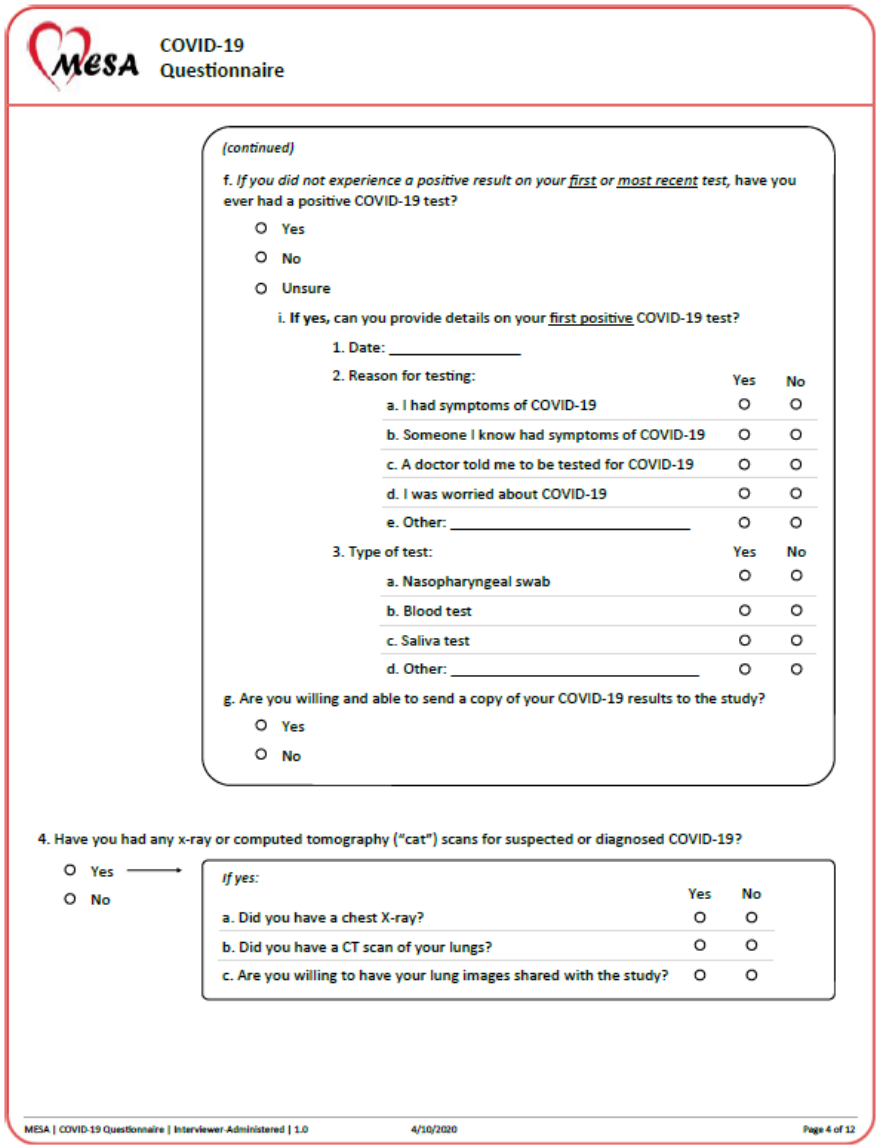
f. If you did not experience a positive result on your first or most recent test, have you ever had a positive COVID-19 test?	*f. Complete item if:* *d. participant's first and only result was negative* *OR* *e. participant has had more than one test and most recent test was negative* *Else, proceed to item g.*
○ Yes	*Proceed to sub-item f.i.* *See explanation for item d.i. to d.iv.*
○ No	*Proceed to g.*
○ Unsure	*"Unsure" includes if test result is pending or inconclusive.* *Proceed to g.*
g. Are you willing and able to send a copy of your COVID-19 results to the study?	*If yes, arrange for results to be sent.*

4. Have you had any x-ray or computed tomography ("cat") scans for suspected or diagnosed COVID-19?
   - f. Yes → Proceed to box below.
   - g. No → Proceed to question 5.

If answered "Yes" to #4:

Item	**Explanation**
a. Did you have a chest X-ray?	*a. Record response.*
b. Did you have a CT scan of your lungs?	*b. Record response.*
c. Are you willing to have your lung images shared with the study?	*c. If yes, arrange for results to be sent.*



COVID-19 Questionnaire

(continued)

f. If you did not experience a positive result on your first or most recent test, have you ever had a positive COVID-19 test?

- O Yes
- O No
- O Unsure

i. **If yes,** can you provide details on your first positive COVID-19 test?

1. Date: _____

2. Reason for testing:

	Yes	No
a. I had symptoms of COVID-19	O	O
b. Someone I know had symptoms of COVID-19	O	O
c. A doctor told me to be tested for COVID-19	O	O
d. I was worried about COVID-19	O	O
e. Other: _____	O	O

3. Type of test:

	Yes	No
a. Nasopharyngeal swab	O	O
b. Blood test	O	O
c. Saliva test	O	O
d. Other: _____	O	O

g. Are you willing and able to send a copy of your COVID-19 results to the study?

- O Yes
- O No

4. Have you had any x-ray or computed tomography ("cat") scans for suspected or diagnosed COVID-19?

- O Yes →
- O No

If yes:

	Yes	No
a. Did you have a chest X-ray?	O	O
b. Did you have a CT scan of your lungs?	O	O
c. Are you willing to have your lung images shared with the study?	O	O

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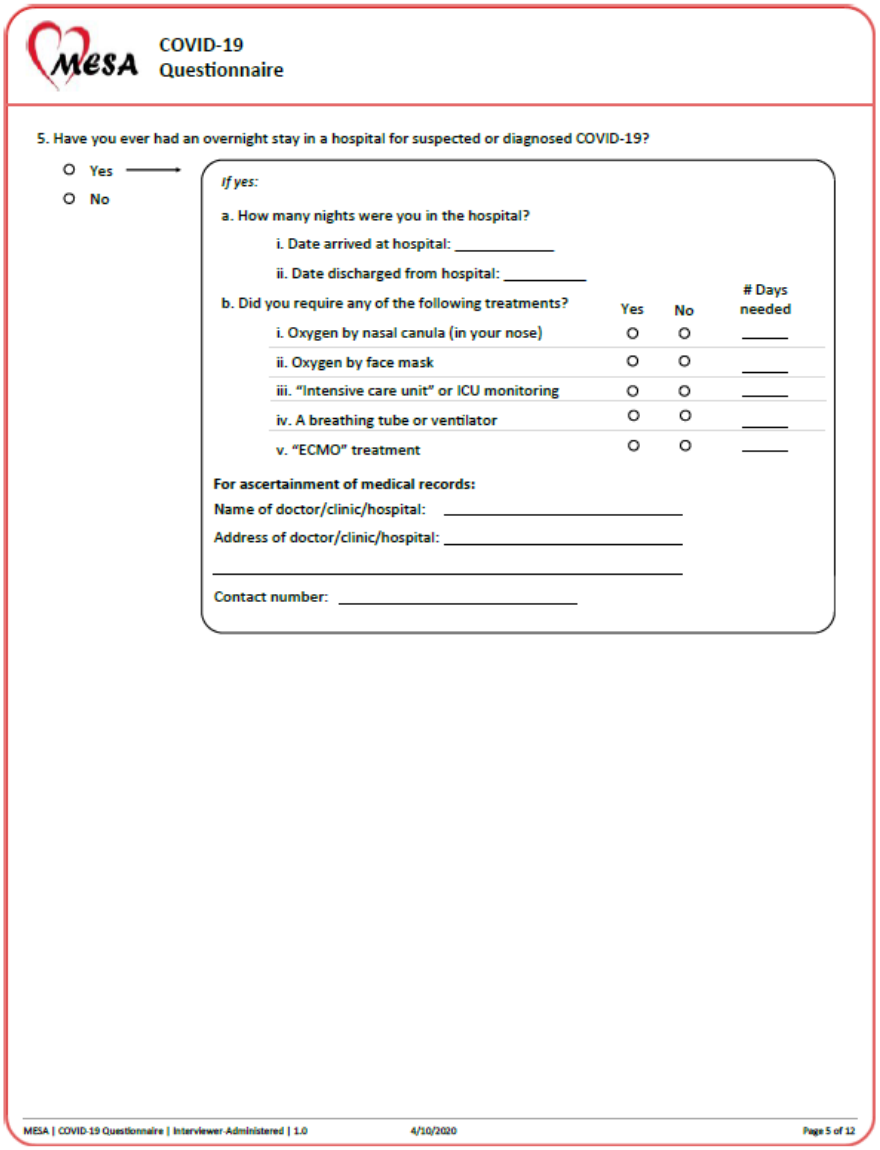
5. Have you ever had an overnight stay in a hospital for suspected or diagnosed COVID-19?
   - h. Yes → Proceed to box below
   - i. No → Proceed to question 7.

If answered "Yes" to #5:

Item	Explanation
a. How many nights were you in the hospital?	*Record number of days*
i. Date arrived at hospital:	*a.i. If date of arrival and formal admit date are different, record the earlier date.*
ii. Date discharged from hospital:	
b. Did you require any of the following treatments?	*b.i. to b.v. "# Days needed" calculated as the difference between calendar days treatment started and treatment stopped.*
For ascertainment of medical records: Name of doctor/clinic/hospital *where test or diagnosis was obtained*: _____ Address of doctor/clinic/hospital: _____ Contact number: _____	*Ask for contact information of doctor/clinic/hospital <u>where COVID-19 test was obtained</u>*



COVID-19 Questionnaire

5. Have you ever had an overnight stay in a hospital for suspected or diagnosed COVID-19?

O Yes → *If yes:*

a. How many nights were you in the hospital?

i. Date arrived at hospital: _____

ii. Date discharged from hospital: _____

b. Did you require any of the following treatments?	Yes	No	# Days needed
i. Oxygen by nasal canula (in your nose)	O	O	_____
ii. Oxygen by face mask	O	O	_____
iii. "Intensive care unit" or ICU monitoring	O	O	_____
iv. A breathing tube or ventilator	O	O	_____
v. "ECMO" treatment	O	O	_____

For ascertainment of medical records:

Name of doctor/clinic/hospital: _____

Address of doctor/clinic/hospital: _____

_____

Contact number: _____

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6. If you were hospitalized for suspected or diagnosed COVID-19, how were you discharged?

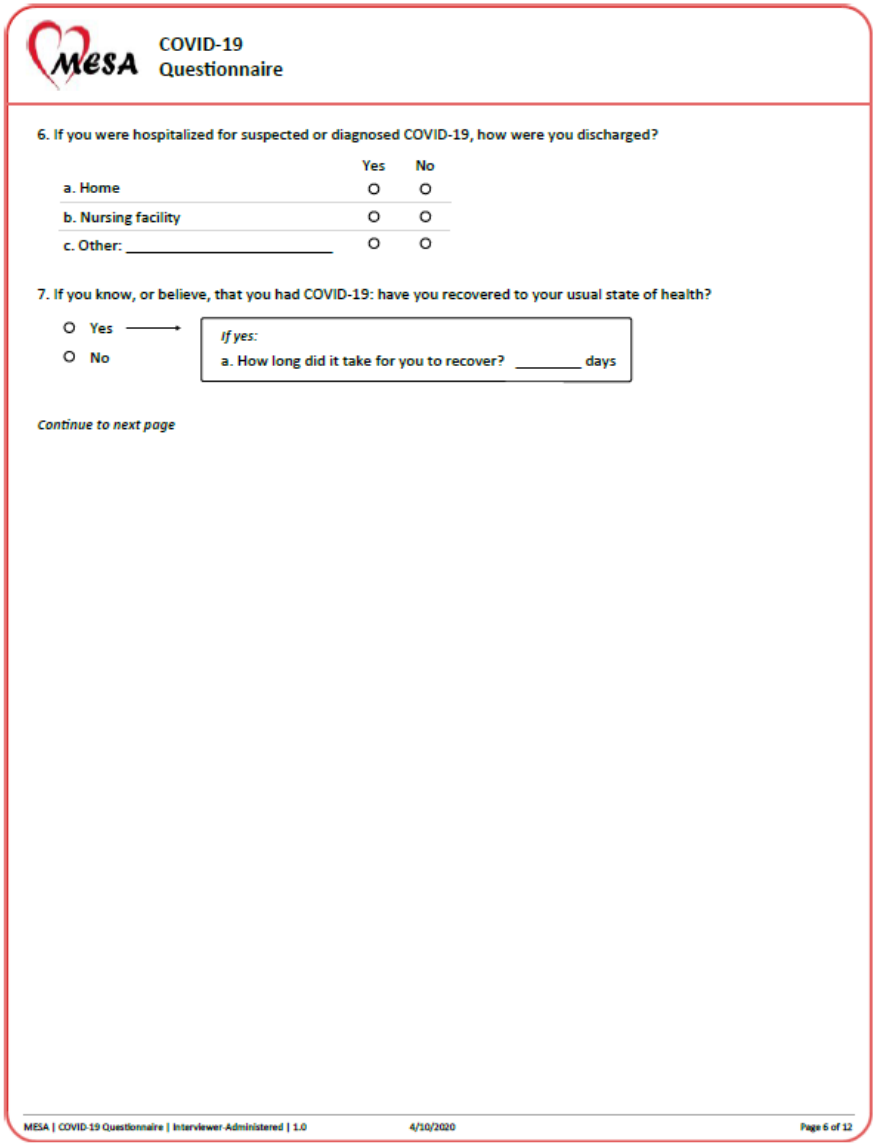
   Where did the participant live after being discharged?

○ Home	*Record response.*
○ Nursing facility	*Any facility in which nursing care is available or necessary. Record response.*
○ Other	*If answer to a and b was "no", record response to c. If answer to a or b was "yes", do not record a response.*

7. If you know, or believe, that you had COVID-19: have you recovered to your usual state of health?

   To be answered if participant answered question #1 as "Yes, definitely" or "Yes, I think so" or "Maybe". If not, proceed to question #8 on page 8.

○ Yes	*Record response to the follow-up item:* a. How long did it take for you to recover? ○ *Days calculated as the difference in calendar days between day first felt symptoms and first day returned to usual health.* *Proceed to the boxed items on page 6, prefaced with If yes to Q7: For participants who have recovered from symptoms related to COVID-19 illness:"*
○ No	*Proceed to the boxed items on page 7, prefaced with "If no to Q7: For participants who continue to have symptoms related to COVID-19 illness:"*



COVID-19 Questionnaire

6. If you were hospitalized for suspected or diagnosed COVID-19, how were you discharged?

	Yes	No
a. Home	O	O
b. Nursing facility	O	O
c. Other: _____	O	O

7. If you know, or believe, that you had COVID-19: have you recovered to your usual state of health?

O Yes → *If yes:* a. How long did it take for you to recover? _____ days

O No

Continue to next page

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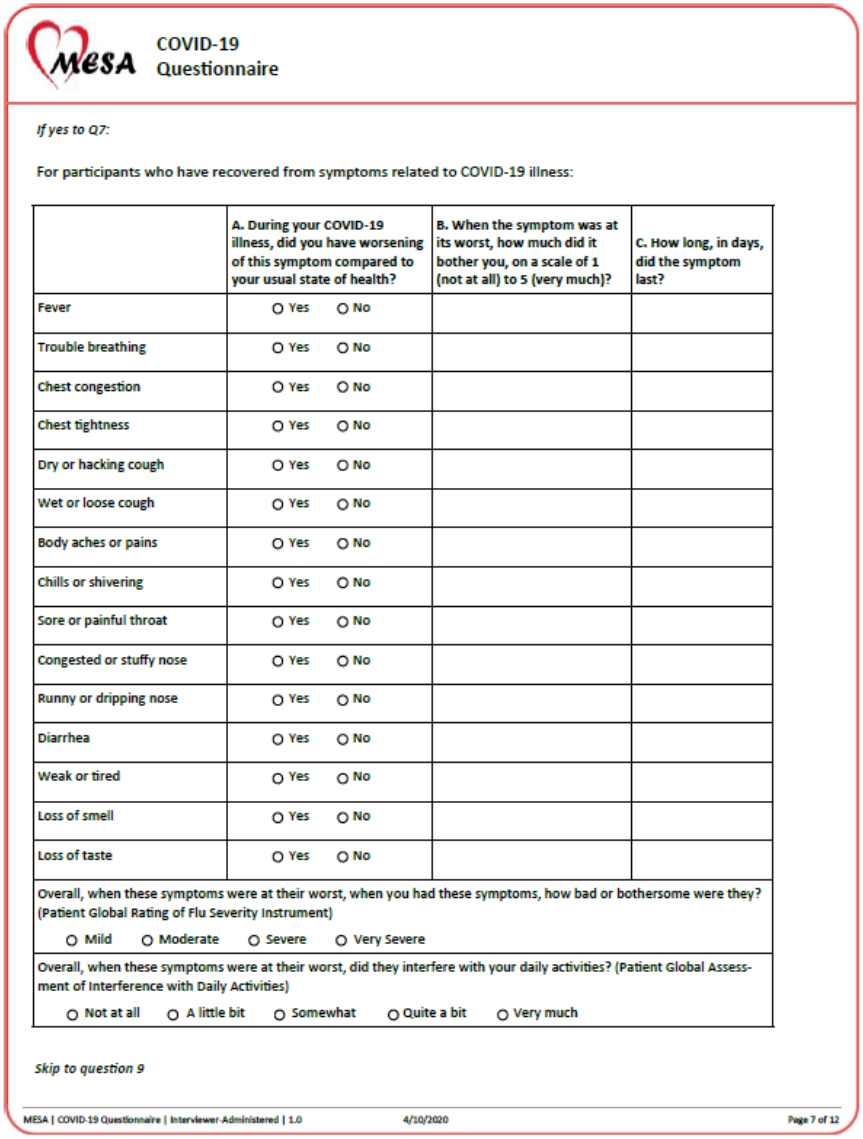
If yes to Q7:

For participants who have recovered from symptoms related to COVID-19 illness:

- *For each symptom (row), record response to A. If A is "yes", record response to items B and C. If A is "No", proceed directly to next symptom (row).*
- B: *response options 1 to 5 correspond to: 1 ("Not at all"), 2 ("A little bit"), 3 ("Somewhat"), 4 ("Quite a bit"), and 5 ("Very much").*
- C: *Calculated in days as the difference between calendar days symptom started and symptom stopped.*
- Item: Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they?
  - *Record response as "Mild", "Moderate", "Severe", or "Very Severe"*
- Item: Overall, when these symptoms were at their worst, did they interfere with your daily activities?
  - *Record response as "Not at all", "A little bit", "Somewhat", "Quite a bit" or "Very much"*
- *After completing page 6, proceed directly to question #9.*



COVID-19 Questionnaire

If yes to Q7:

For participants who have recovered from symptoms related to COVID-19 illness:

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?	B. When the symptom was at its worst, how much did it bother you, on a scale of 1 (not at all) to 5 (very much)?	C. How long, in days, did the symptom last?
Fever	O Yes O No		
Trouble breathing	O Yes O No		
Chest congestion	O Yes O No		
Chest tightness	O Yes O No		
Dry or hacking cough	O Yes O No		
Wet or loose cough	O Yes O No		
Body aches or pains	O Yes O No		
Chills or shivering	O Yes O No		
Sore or painful throat	O Yes O No		
Congested or stuffy nose	O Yes O No		
Runny or dripping nose	O Yes O No		
Diarrhea	O Yes O No		
Weak or tired	O Yes O No		
Loss of smell	O Yes O No		
Loss of taste	O Yes O No		

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

O Mild O Moderate O Severe O Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

O Not at all O A little bit O Somewhat O Quite a bit O Very much

Skip to question 9

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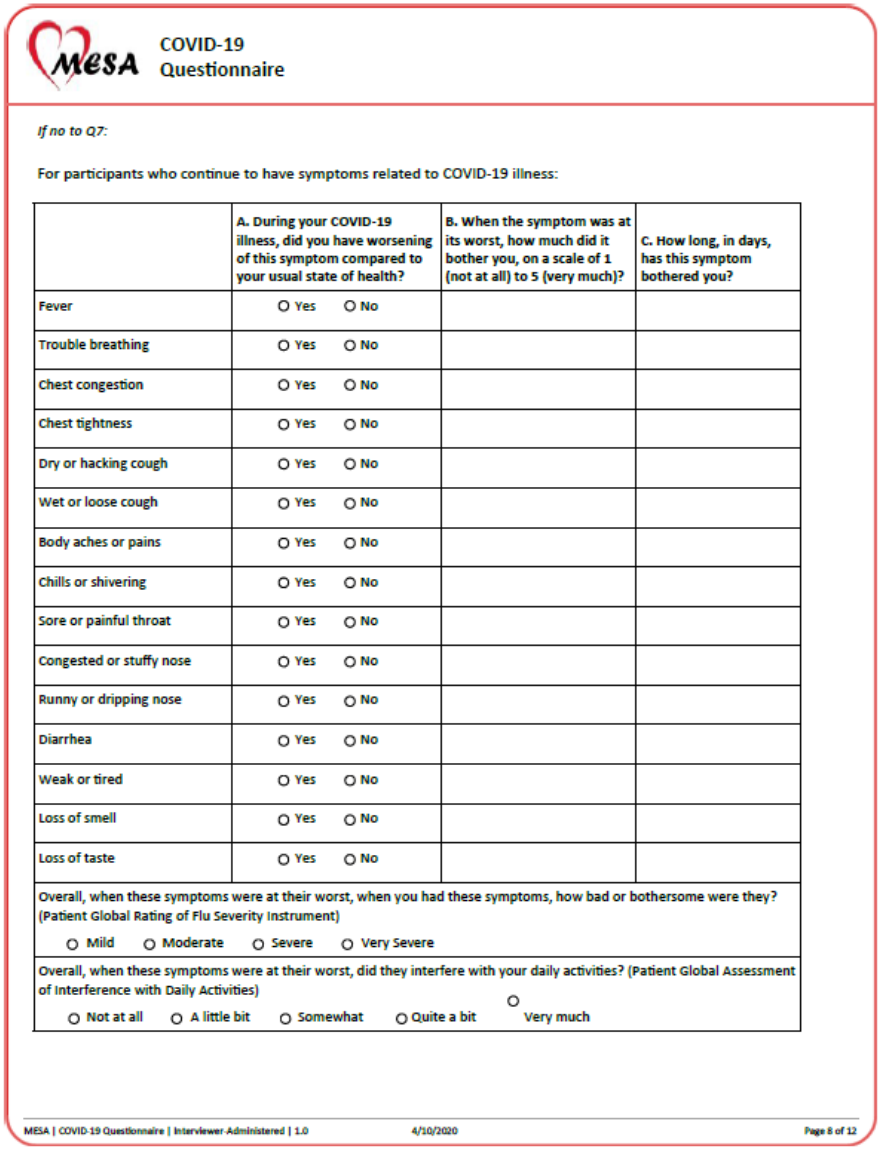
If no to Q7:

For participants who continue to have symptoms related to COVID-19 illness:

- *For each symptom (row), record response to A. If A is "yes", record response to items B and C. If A is "No", proceed directly to next symptom (row).*
- B: *response options 1 to 5 correspond to: 1 ("Not at all"), 2 ("A little bit"), 3 ("Somewhat"), 4 ("Quite a bit"), and 5 ("Very much").*
- C: *Calculated in days as the difference between calendar days symptom started and symptom stopped.*
- Item: Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they?
  - *Record response as "Mild", "Moderate", "Severe", or "Very Severe"*
- Item: Overall, when these symptoms were at their worst, did they interfere with your daily activities?
  - *Record response as "Not at all", "A little bit", "Somewhat", "Quite a bit" or "Very much"*
- *After completing page 7, proceed directly to question #9.*



COVID-19 Questionnaire

If no to Q7:

For participants who continue to have symptoms related to COVID-19 illness:

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?	B. When the symptom was at its worst, how much did it bother you, on a scale of 1 (not at all) to 5 (very much)?	C. How long, in days, has this symptom bothered you?
Fever	O Yes O No		
Trouble breathing	O Yes O No		
Chest congestion	O Yes O No		
Chest tightness	O Yes O No		
Dry or hacking cough	O Yes O No		
Wet or loose cough	O Yes O No		
Body aches or pains	O Yes O No		
Chills or shivering	O Yes O No		
Sore or painful throat	O Yes O No		
Congested or stuffy nose	O Yes O No		
Runny or dripping nose	O Yes O No		
Diarrhea	O Yes O No		
Weak or tired	O Yes O No		
Loss of smell	O Yes O No		
Loss of taste	O Yes O No		

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

O Mild O Moderate O Severe O Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

O Not at all O A little bit O Somewhat O Quite a bit O Very much

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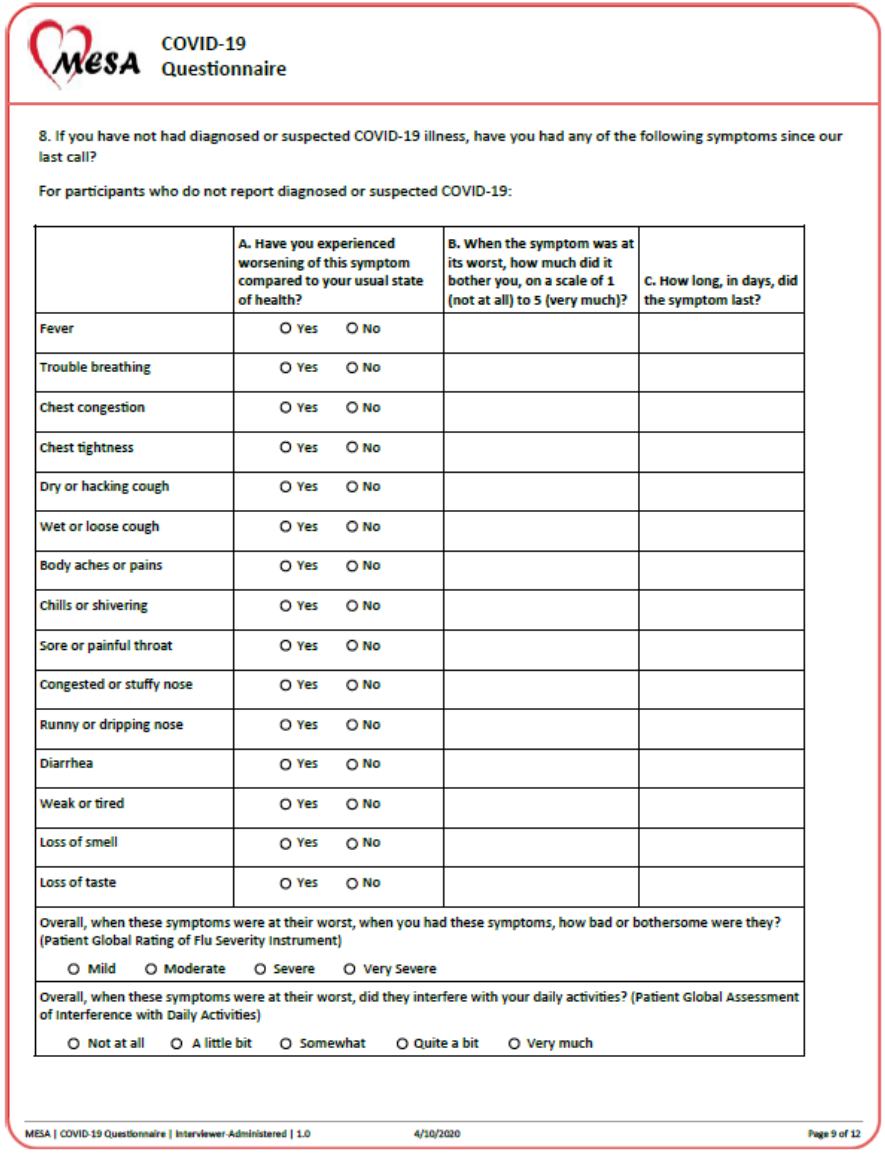
8. If you have not had diagnosed or suspected COVID-19 illness, have you had any of the following symptoms since our last call?

For participants who do not report diagnosed or suspected COVID-19:
To be answered only if participant answered question #1 as "No".

- *For each symptom (row), record response to A. If A is "yes", record response to items B and C. If A is "No", proceed directly to next symptom (row).*
- B: *response options 1 to 5 correspond to: 1 ("Not at all"), 2 ("A little bit"), 3 ("Somewhat"), 4 ("Quite a bit"), and 5 ("Very much").*
- C: *Calculated in days as the difference between calendar days symptom started and symptom stopped.*
- Item: Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they?
  - *Record response as "Mild", "Moderate", "Severe", or "Very Severe"*
- Item: Overall, when these symptoms were at their worst, did they interfere with your daily activities?
  - *Record response as "Not at all", "A little bit", "Somewhat", "Quite a bit" or "Very much"*
- *After completing page 8, proceed to question #9.*



COVID-19 Questionnaire

8. If you have not had diagnosed or suspected COVID-19 illness, have you had any of the following symptoms since our last call?

For participants who do not report diagnosed or suspected COVID-19:

	A. Have you experienced worsening of this symptom compared to your usual state of health?	B. When the symptom was at its worst, how much did it bother you, on a scale of 1 (not at all) to 5 (very much)?	C. How long, in days, did the symptom last?
Fever	O Yes O No		
Trouble breathing	O Yes O No		
Chest congestion	O Yes O No		
Chest tightness	O Yes O No		
Dry or hacking cough	O Yes O No		
Wet or loose cough	O Yes O No		
Body aches or pains	O Yes O No		
Chills or shivering	O Yes O No		
Sore or painful throat	O Yes O No		
Congested or stuffy nose	O Yes O No		
Runny or dripping nose	O Yes O No		
Diarrhea	O Yes O No		
Weak or tired	O Yes O No		
Loss of smell	O Yes O No		
Loss of taste	O Yes O No		

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

O Mild O Moderate O Severe O Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

O Not at all O A little bit O Somewhat O Quite a bit O Very much

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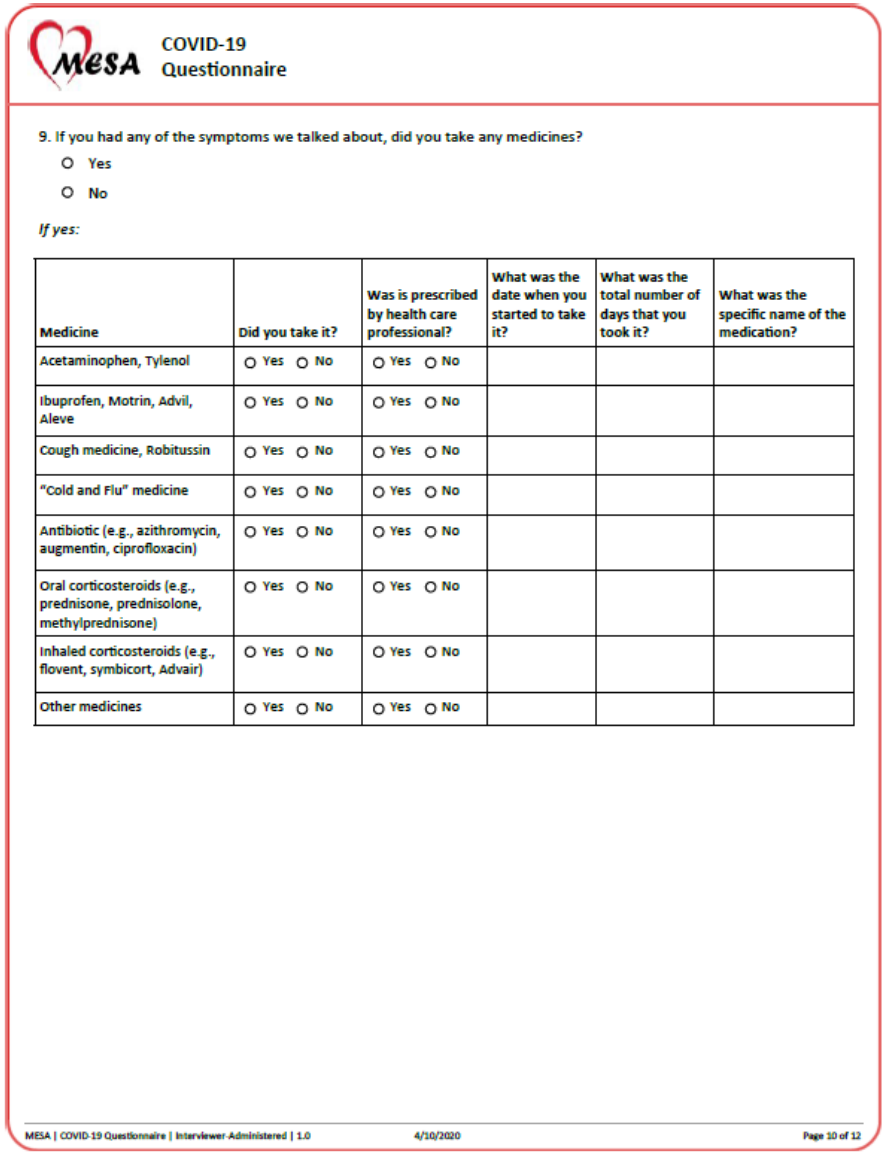
9. If you had any of the symptoms we talked about, did you take any medicines?
    - ○ Yes *Proceed to the table of medicines. For each group of medicines (each row), record response to:*
        - Did you take it?
        - Was it prescribed by health care professional?
        - What was the date when you started to take it?
        - What was the total number of days that you took it?
            - ○ *Difference in calendar days between date started and date stopped.*
        - What was the specific name of the medication?
            - ○ *This would be the name on the bottle, trade name, etc.*
    - ○ No *Proceed to question #10.*



COVID-19 Questionnaire

9. If you had any of the symptoms we talked about, did you take any medicines?

○ Yes

○ No

If yes:

Medicine	Did you take it?	Was is prescribed by health care professional?	What was the date when you started to take it?	What was the total number of days that you took it?	What was the specific name of the medication?
Acetaminophen, Tylenol	○ Yes ○ No	○ Yes ○ No			
Ibuprofen, Motrin, Advil, Aleve	○ Yes ○ No	○ Yes ○ No			
Cough medicine, Robitussin	○ Yes ○ No	○ Yes ○ No			
"Cold and Flu" medicine	○ Yes ○ No	○ Yes ○ No			
Antibiotic (e.g., azithromycin, augmentin, ciprofloxacin)	○ Yes ○ No	○ Yes ○ No			
Oral corticosteroids (e.g., prednisone, prednisolone, methylprednisone)	○ Yes ○ No	○ Yes ○ No			
Inhaled corticosteroids (e.g., flovent, symbicort, Advair)	○ Yes ○ No	○ Yes ○ No			
Other medicines	○ Yes ○ No	○ Yes ○ No			

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10. Has anyone in your household (or, the place you are residing) been tested for COVID-19?

○ Yes *Proceed to the boxed items.*

a. When was/were the tests conducted? _____

b. What was the result of that (those) test(s)?

- ○ Positive
  - Did you change your behavior at home? *(As a result of the test performed on the household member/s)*
    - Yes → *Record whether or not the participant implemented each of the 3 behaviors listed. Then continue to question #11.*
    - No → *Proceed to question #11.*
- ○ Negative → *Proceed to question #11.*
- ○ Unsure → *Proceed to question #11.*

Repeat questions a and b for up to four COVID-19 tests

○ No *Proceed to question #11.*

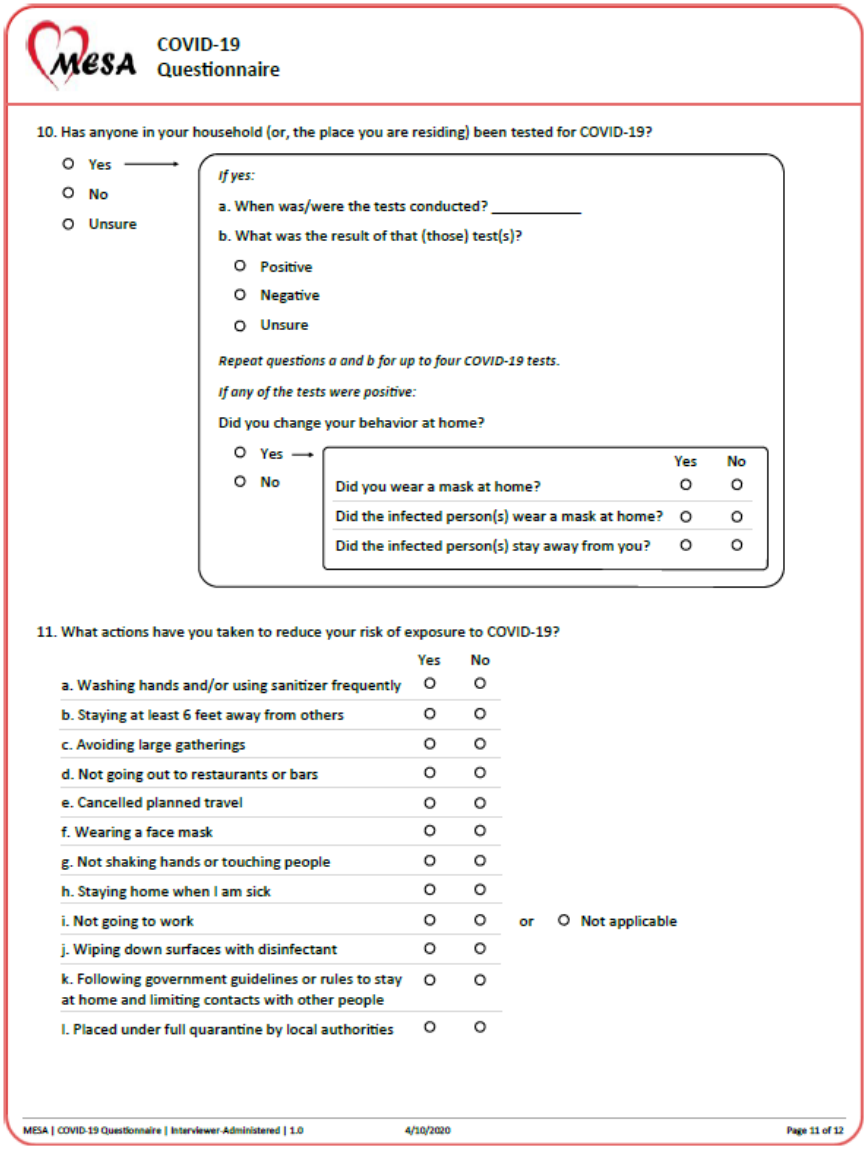
○ Unsure *Proceed to question #11.*

11. What actions have you taken to reduce your risk of exposure to COVID-19?

Record a response for each of the following items a. to l.

a. Washing hands and/or using sanitizer frequently
b. Staying at least 6 feet away from others
c. Avoiding large gatherings
d. Not going out to restaurants or bars
e. Cancelled planned travel
f. Wearing a face mask
g. Not shaking hands or touching people
h. Staying home when I am sick
i. Not going to work
j. Wiping down surfaces with disinfectant
k. Following government guidelines or rules to stay at home and limiting contacts with other people
l. Placed under full quarantine by local authorities

Continue to question #12.



COVID-19 Questionnaire

10. Has anyone in your household (or, the place you are residing) been tested for COVID-19?

○ Yes → *If yes:*
a. When was/were the tests conducted? _____
b. What was the result of that (those) test(s)?
○ Positive
○ Negative
○ Unsure

Repeat questions a and b for up to four COVID-19 tests.

If any of the tests were positive:

Did you change your behavior at home?

○ Yes →

	Yes	No
Did you wear a mask at home?	○	○
Did the infected person(s) wear a mask at home?	○	○
Did the infected person(s) stay away from you?	○	○

○ No

11. What actions have you taken to reduce your risk of exposure to COVID-19?

	Yes	No
a. Washing hands and/or using sanitizer frequently	○	○
b. Staying at least 6 feet away from others	○	○
c. Avoiding large gatherings	○	○
d. Not going out to restaurants or bars	○	○
e. Cancelled planned travel	○	○
f. Wearing a face mask	○	○
g. Not shaking hands or touching people	○	○
h. Staying home when I am sick	○	○
i. Not going to work	○	○
j. Wiping down surfaces with disinfectant	○	○
k. Following government guidelines or rules to stay at home and limiting contacts with other people	○	○
l. Placed under full quarantine by local authorities	○	○

or ○ Not applicable

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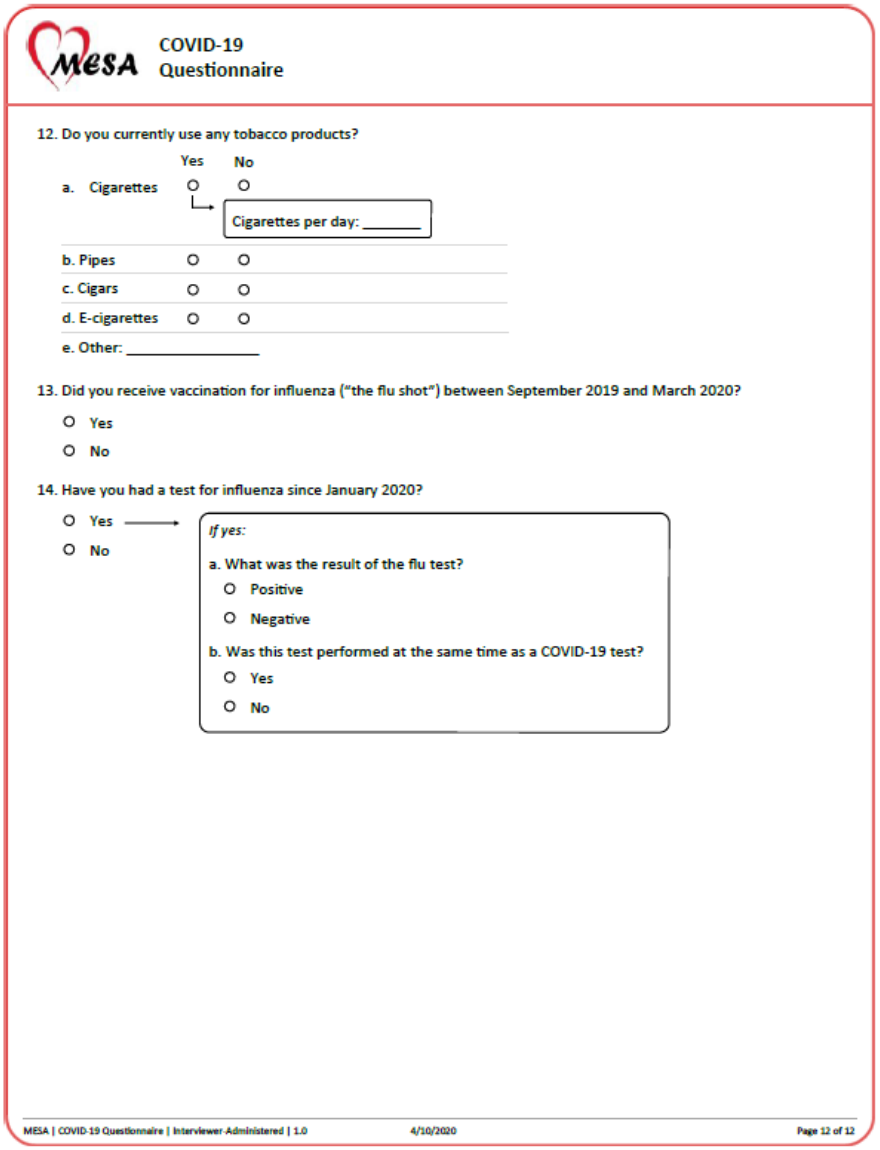
12. Do you currently use any tobacco products?
Record response for each item a. to e. Note that item a has a follow-up question if answered "yes".

13. Did you receive vaccination for influenza ("the flu shot") between September 2019 and March 2020?
Record response.

14. 14. Have you had a test for influenza since January 2020?

- ○ Yes — *Proceed to boxed items a. and b.*
  a. What was the result of the flu test?
  b. Was this test performed at the same time as a COVID-19 test?
  MESA-COVID interview completed.
- ○ No — *MESA-COVID interview completed.*



MESA COVID-19 Questionnaire

12. Do you currently use any tobacco products?

	Yes	No
a. Cigarettes	O	O
b. Pipes	O	O
c. Cigars	O	O
d. E-cigarettes	O	O

→ Cigarettes per day: _____

e. Other: _____

13. Did you receive vaccination for influenza ("the flu shot") between September 2019 and March 2020?

O Yes
O No

14. Have you had a test for influenza since January 2020?

O Yes →
O No

If yes:

a. What was the result of the flu test?
O Positive
O Negative

b. Was this test performed at the same time as a COVID-19 test?
O Yes
O No

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