CanPath COVID-19 Second Timepoint Questionnaire

Last year, you completed the CanPath COVID-19 Antibody Study questionnaire and provided your blood spot sample for COVID-19 antibodies analysis.

This shorter questionnaire is designed to learn about changes to your physical and mental health from the impact of COVID-19, as well as your current vaccine status.

This questionnaire should be completed within **1 WEEK** of receiving it. You do not need to finish this questionnaire all at once. You may pause, save your progress and return to it at a later time.

Please enter a response to each question on the screen. If there are questions you do not feel comfortable answering, please select the "Prefer not to answer" option where applicable.

COVID-19 DIAGNOSES

DG01. Since January 1, 2021, do you think you currently have, or have had COVID-19?

1 Yes
0 No [SKIP TO DG05]
9 Don't know [Skip to DG05]

DG02. Why do you think you have, or have had, COVID-19?
Select all that apply:

1 Took a self-assessment online
2 Had symptoms that could be COVID-related (e.g., fever, sore throat, runny nose, difficulty breathing, etc.) that cannot be attributed to a previously existing condition
3 Nasal/throat/rapid test result
4 Told by a health care provider
5 Had contact with someone who tested positive for COVID-19
6 Other – please specify: _____

DG03. [if yes to Contact with someone who tested positive for COVID-19] On which date did you have first contact with this person after they were diagnosed with COVID-19?
If you don't remember exactly when, please choose an approximate date.

DD/MM/YYYY (date calendar – participant chooses date)
Don't know

DG04. [if yes to Contact with someone who tested positive for COVID-19] Who was this person with COVID-19?

Spouse or partner
Family member living in the same place

Family member living in another place
Housemate
Friend
Work colleague
Other - please specify: _____

DG05. Since January 1, 2021, have you been tested for COVID-19 (including a rapid test, nasal swab and/or blood testing)?
1 Yes
2 No [SKIP to SY01]

DG06. [if YES] How many times have you been tested? For serology/antibody testing please do not include the test you will be doing as part of this study.
A maximum of 8 tests can be reported. Please report all positive tests. Report test results from oldest to most recent.
1
2
3
4
5
6
7
8

DG07. For your first test, what was the type of test?
Rapid test (a rapid antigen test with results in 15-20 minutes)
Viral test (a nasal or throat swab for current infection)
Anitbody/serology test (blood test for past infection)

DG08. What was the date of your first test?
If you don't remember exactly when, please choose an approximate date.
DD/MM/YYYY
Don't know

DG09. What was the result of your first test?
Negative
Positive
Don't know

DG07 – DG09 will be repeated up to 8 times depending on the number of tests reported in DG06.

COVID-19 - CARE/HOSPITAL RELATED INFORMATION

The following questions are presented to participants with a positive test result for COVID-19.

CH01. Since January 1, 2021, were you hospitalized because of COVID-19?
1 Yes
0 No [SKIP to SY01]

CH02. [IF YES] What date did you get admitted to the hospital?
DD-MM-YYYY
9 Don't know

CH03. [IF YES] How many days were you in the hospital?
Note: to register your answers after you've typed them, simply click somewhere else on the page.
Number of days: _____
9 Don't know

CH04. [IF YES] Were you admitted to an intensive care unit?
1 Yes
0 No
9 Don't know

CH05. [IF CH04=YES] How long did you stay in the intensive care unit?
Note: If you don't remember the exact duration, please provide the best estimate that you can. This response must be less than or equal to the number of days spent in the hospital. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.
Number of days: _____
Don't know

CH06. Did you continue to experience COVID-19 symptoms or complications related to hospitalization after you were discharged?
1 Yes
0 No
9 Don't know

COVID-19 SYMPTOMS

We are interested in whether you've experienced flu-like and other symptoms, which may be related to COVID-19. For these next questions, please consider any symptoms which ***are not due to other health issues*** *you might usually experience/expect, such as seasonal allergies, existing medical conditions, etc.*

SY01. Since January 1, 2021, have you experienced any of the following symptoms? Please do not include symptoms related to factors you might usually experience/expect, such as seasonal allergies, asthma, COPD, or other existing medical conditions.

- Fever ≥38°C
- Dry Cough
- Wet cough (a cough that produces mucus)
- Runny nose
- Sinus pain
- Ear pain
- Sore throat
- Hoarseness
- Shortness of breath or difficulty breathing
- Headache
- Fatigue
- General muscle and/or joint aches and pains
- Chills or shivering
- Loss of taste
- Loss of sense of smell
- Diarrhea
- Loss of appetite
- Nausea
- Vomiting
- Wheezing
- Chest pain
- Confusion
- Dizziness
- Abdominal Pain
- Other respiratory symptoms

1 Yes
0 No [SKIP TO RF01]

SY02. Please indicate which symptoms you've experienced and the severity.

	0 No	1 Mild	3 Severe
Fever ≥38°C			

Dry Cough			
Wet cough (Cough that produces mucus)			
Runny nose			
Sinus pain			
Ear pain			
Sore throat			
Hoarseness			
Shortness of breath or difficulty breathing			
Headache			
Fatigue			
General muscle and/or joint aches and pains			
Chills or shivering			
Loss of taste			
Loss of sense of smell			
Diarrhea			
Loss of appetite			
Nausea			
Vomiting			
Wheezing			
Chest pain			
Confusion			
Dizziness			
Abdominal pain			
Other respiratory symptoms			

SY03. Did you experience any other symptoms?
1 Yes – please specify:_____
0 No other symptoms

SY04. [IF YES] How severe were these other symptoms?
Mild
Severe
Don't know

SY05. [IF YES TO ANY SYMPTOMS] When did you *first* experience these symptoms?
If you don't remember the exact date, please provide the best estimate that you can.
Value (DD-MM-YYYY)
Don't know

SY06. [IF YES TO ANY SYMPTOMS] When did you experience the most *recent* symptoms?
Note: The date entered must be later than, or the same as, the date you first experienced symptoms. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.
Value (DD-MM-YYYY)
Don't know

SY07. [IF YES TO ANY SYMPTOMS] While you were experiencing COVID-19 related symptoms, did you have close contact with any of the following people? Close contact means physical contact such as hugging, kissing, shaking hands, etc.
Please be sure to respond to all the questions. Select 'No' for a question if it doesn't apply to you, or 'Don't know' if you are not sure.

	Yes	No	Don't know
Spouse or partner			
Family members living in the same place			
Family members living in another place			
Housemates			
Friends			
Work colleagues			

SY08. [IF YES] Has any of those person(s) developed COVID-related symptoms?
Yes
No
Don't know

SY09. [IF YES] For those person(s) that developed COVID-related symptoms, which category/categories did they belong to and how many individuals were affected?
Select all that apply. Note: Values between 1-30 accepted. Please use numbers only. Avoid special characters such as "/".
Spouse or partner
Family members living in the same place - number of individuals:_____
Family members living in another place - number of individuals:_____
Housemates - number of individuals: _____

Friends - number of individuals:_____
Work colleagues - number of individuals:_____

SY10. [IF YES TO ANY SYMPTOMS] Do you continue to experience COVID-19 symptoms or complications?
1 Yes
0 No
9 Don’t know

RISK FACTORS

RF01. At the present time, are you smoking cigarettes daily, occasionally, or not at all?

1 Daily (At least one cigarette every day for the past 30 days)
2 Occasionally (At least one cigarette in the past 30 days, but not every day)
3 Not at all (You did not smoke at all in the past 30 days)

RF02. At the present time, are you using electronic cigarettes, also known as an e-cigarettes?

Vaping products have many names, such as: e-cigarettes, vape pens, vapes, mods, tanks, and e-hookahs. They may also be known by various brand names.

1 Daily (At least one e-cigarette every day for the past 30 days)
2 Occasionally (At least one e-cigarette in the past 30 days, but not every day)
3 Not at all (You did not use e-cigarettes at all in the past 30 days)

RF03. At the present time, are you using cannabis?

1 Daily (At least once every day for the past 30 days)
2 Occasionally (At least once in the past 30 days, but not every day)
3 Not at all (You did not use cannabis at all in the past 30 days)
4 I have never used cannabis
8 Prefer not to answer

RF04. [if daily or occasionally] Which of the following methods to consume cannabis do you use most often?

1 Smoked
2 Vaporized
3 Consumed in food or drink
4 Other
8 Prefer not to answer
9 Don't know

RF05. At the present time, how often do you currently drink alcohol?

7 6 to 7 times a week
6 4 to 5 times a week
5 2 to 3 times a week
4 Once a week
3 2 to 3 times a month
2 About once a month
1 Less than once a month
0 Never
9 Don't know

MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since January 2021. ***Please note that a mental health professional will not follow-up with you if your responses to these questions suggest you are in distress.*** *If you are experiencing stress or anxiety and would like to access support, please reach out to mental health services available in your area.*

PI01. Since January 1, 2021, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

PI02. [IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

PI03. Since January 1, 2021, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				

Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				

PI04. [IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

OTHER

OT02 Have you received a vaccine against COVID-19?
Yes
No (skip to OT17)

OT03. [IF YES] Did you receive this vaccine in your home province?
Yes
No

OT04 [IF NO] Where did you receive this vaccine (province, state or country)?
Open text

[IF YES to OT02]

OT05. Which vaccine(s) did you receive? Select all that apply.	**OT06. How many doses did you receive?**	**OT07. What date did you receive each dose of COVID-19 vaccine(s)?** YYYYMMDD Prefer not to answer	**OT08. In what setting did you receive the vaccine?**
Pfizer and BioNTech mRNA vaccine Moderna mRNA vaccine AstraZeneca Oxford / Covishield vaccine Janssen (Johnson & Johnson) vaccine Other - please specify (Open Text)	1 2 3 4	Dose 1: DD/MM/YYYY Dose 2 (if required): DD/MM/YYYY Dose 3 (if required): DD/MM/YYYY Dose 4 (if required): DD/MM/YYYY Prefer not to answer	Hospital Public health clinic Pharmacy Nursing station Physician office Long-term care home Workplace clinic Other – please specify (open text)
Don't know [Skip to OT09]			

Repeat OT06 – OT08 as many times as indicated in OT05.

OT09 [IF YES to OT02] Did you experience any side-effects (within the first few days) after receiving any dose of the COVID-19 vaccine?
Yes
No (SKIP to OT17)
Prefer not to answer

[IF YES to OT02] OT10. Did you experience the following side-effects in the arm where you had the needle?
Please be sure to respond to all symptoms.

	No	Yes - Mild	Yes - Moderate	Yes - Severe	Prefer not to answer
Redness					
Itching/hives					
Prickling/tingling					
Soreness					
Pain					
Swelling					
Bruising					

[IF YES to OT02] OT11. Did you experience the following other side-effects?
Please be sure to respond to all symptoms.

	No	Mild	Moderate	Severe	Prefer not to answer
Fatigue					
Headache					
Fever >38°C					
Chills or shivering					
Muscle aches/pains					
Sore throat					
Difficulty swallowing					
Shortness of breath or difficulty breathing					
Wheezing					
Chest pain					
Fast heartbeat					
Blurry vision					
Dizziness or light-headed					
Abdominal pain					
Nausea					

Vomiting					
Diarrhea					
Rash, redness, or hives on other places on your body (other than the arm where you had the needle)					
Swelling of other places on your body (other than the arm where you had the needle)					
Numbness (in places of your body other than the arm where you had the needle)					
Prickling or tingling (in places of your body other than the arm where you had the needle)					

OT12. [IF YES to OT02] Did you experience any other side-effects not mentioned above?
Yes – please specify (open text)
No

OT13. [If Mild/Moderate/Severe to any symptoms in OT10 or OT11 or YES to OT12] Did you contact a healthcare provider about these symptoms?
Yes
No
Prefer not to answer

OT14. [If Mild/Moderate/Severe to any symptoms in OT10 or OT11 or YES to OT12] Did you require hospitalization for these symptoms?
Yes
No
Prefer not to answer

OT15. [If Mild/Moderate/Severe to any symptoms in OT10 or OT11 or YES to OT12] How long did these symptoms last?
Note: to register your answers after you've typed them, simply click somewhere else on the page.
___ days

Don’t know

OT17. What are the main concerns you have around getting the vaccine? (Select all that apply. If you have already received the vaccine, what were your main concerns?)
No concerns about getting the vaccine
I am worried about unknown future effects of the vaccine
I am worried about side-effects
Vaccines are limited and other people need it more than me
I don’t trust vaccines
I previously tested positive for COVID-19 and so should have protection
The chances of me becoming seriously unwell from COVID-19 are low
The chances of me catching COVID-19 are low
The impact of COVID-19 is being greatly exaggerated
I don’t think it would be effective at preventing me from catching COVID-19
I have a condition which would make it unsafe for me
Herd immunity will protect me even if I don’t have the vaccine
It’s not offered at a location that is easy for me to get to
Other – please specify (open text)

OT18. What are your main reasons for getting the vaccine? (Select all that apply. If you have already received the vaccine, what were your main reasons?)
To stop me from catching COVID-19 or getting very ill from it
To allow my social and family life to get back to normal
To protect other people from catching COVID-19
Because the vaccine won’t work unless most people take it
Because I work in an essential service setting
Because I am in contact with people with higher risk
Because it is/was recommended by my healthcare provider
Because it is/was recommended by public health experts
Because it is/was recommended by the government
To allow me to go out of my home safely again
To reduce the disruption to my children’s education
To allow me to return to my workplace
To allow me to get the help or care I need at home
Not applicable – I do not plan on getting the vaccine
Other – please specify (open text)

The following questions may help interpret results from the analysis of the blood spot sample you will provide.

OT19. Have you received a blood transfusion in the past 2 months?
1 Yes

0 No

OT20. Have you received chemotherapy in the past 3 months?
1 Yes
0 No

OT21. Have you received radiotherapy treatment in the last 3 months?
1 Yes
0 No

Click *Finish* to submit this questionnaire.

<u>COMPLETION PAGE</u> (Only visible when questionnaire completed via portal)

Questionnaire Complete

Thank you!

You did it – your COVID-19 Questionnaire has been successfully completed and submitted. Your participation is greatly appreciated and we hope you will continue to take part in future questionnaires.

We will be sending you the blood spot sample collection kit to your home. Once it arrives, please open and follow the directions stated in the information letter.

With your help, we and other participating cohorts are providing researchers with the data they need to understand and track the impact of this pandemic.