MVP COVID-19 Survey Module 1

Study ID _____

NOTES TO INTERVIEWER:

For most questions, read entire list and stop if/when only 1 response can be marked OR keep going if more than one answer can be marked OR if respondent makes clear what response(s) they are choosing. Clarify/confirm as necessary.

Text in brackets, for example, "[READ LIST:]" are not meant to be read to the respondent.

Text in parentheses are meant to provide guidance on how to interpret an answer, and how to select the best response option that is best aligned with/reflective of their answer.

Hello, this is ?

I am a member of the research team at and I am calling to see if you have time to complete a survey for the CSP#2028: EPIC3 study. This survey will take about 20 minutes to complete, and I will ask general questions about your health and lifestyle, as well as your experience with COVID-19.

Is now a good time to get started?

IF No - When would be a better time for me to call back?

IF Yes - Thank you! Please keep in mind that your participation is voluntary, and as we go through the survey, you may refuse to answer any questions. Your responses will be kept confidential and secure according to VA policy. Please also let me know if you need a break from answering questions at any time.

Do you have any questions before we get started?

IF YES, ANSWER QUESTIONS.

IF NO, CONTINUE TO SECTION A.

DISABLE SKIP LOGIC?

- ◯ No
- ◯ Yes

MODULE 1: COVID-19 EXPOSURE/HOUSEHOLD CONTACT

CLICK "NOW" BUTTON TO ENTER MODULE START DATE & TIME.

_____

This section asks about COVID-19 exposure and household contact in the 3 weeks before you entered this study.

1. Have you been in close contact with anyone with COVID-19 like symptoms?

[IF YES, clarify whether that person had a confirmed positive by a test.]
(If a person was confirmed by a test, that is a more definitive response and takes precedence over exposure without confirmed by a test.)

- ◯ Yes, I was in contact with a person with COVID-19 who was confirmed positive by a test
- ◯ Yes, I was in contact with a person with COVID-19 symptoms, but was not confirmed by a test
- ◯ No, not to my knowledge
- ◯ Prefer not to answer

2. Has anyone in your household had COVID-19? Please do not include yourself.	◯ Yes ◯ No ◯ Prefer not to answer
Please indicate the number of people.	_____ (PeopleEnter "999" if prefer not to answer)
3. Are you a healthcare worker helping to manage patients with COVID-19? [READ OPTIONS IF NEEDED]	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
INTERVIEWER: WOULD YOU LIKE TO PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE?	◯ Yes ◯ No
INTERVIEWER: PLEASE PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE.	_____ (Do not enter identifiable information into notes box.)
CLICK "NOW" BUTTON TO ENTER MODULE END DATE & TIME.	_____

MVP COVID-19 Survey Module 2

MODULE 2: COVID-19 SYMPTOMS/DIAGNOSIS & HOSPITALIZATION/TREATMENT

CLICK "NOW" BUTTON TO ENTER MODULE START DATE & TIME.

_____

This section asks about COVID-19-like symptoms and diagnoses in the 3 weeks before you entered this study.

1. In general, would you say your health is: [READ LIST]

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Prefer not to answer

Did you experience any of the following symptoms (more than normal) in the 3 weeks before you entered this study? Please answer "Yes" or "No" next to each symptom.

If you respond Yes, please indicate the date that you first experienced any of these symptoms and the number of consecutive days you experienced any of these symptoms.

2. In the 3 weeks before you entered this study, did you experience:

a. Coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours)

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

- ◯ January (01)
- ◯ February (02)
- ◯ March (03)
- ◯ April (04)
- ◯ May (05)
- ◯ June (06)
- ◯ July (07)
- ◯ August (08)
- ◯ September (09)
- ◯ October (10)
- ◯ November (11)
- ◯ December (12)
- ◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

b. Shortness of breath

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

c. Unusual chest pain or tightness in your chest

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

d. Fatigue (struggling to get out of bed)

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

e. Feeling of heaviness in arms or legs

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

f. Headache

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

g. Loss of sense of smell or taste

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

- ◯ January (01)
- ◯ February (02)
- ◯ March (03)
- ◯ April (04)
- ◯ May (05)
- ◯ June (06)
- ◯ July (07)
- ◯ August (08)
- ◯ September (09)
- ◯ October (10)
- ◯ November (11)
- ◯ December (12)
- ◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

h. Sore throat

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

- ◯ January (01)
- ◯ February (02)
- ◯ March (03)
- ◯ April (04)
- ◯ May (05)
- ◯ June (06)
- ◯ July (07)
- ◯ August (08)
- ◯ September (09)
- ◯ October (10)
- ◯ November (11)
- ◯ December (12)
- ◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

i. Diarrhea, nausea and/or vomiting

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:

_____
(Enter "999" if prefer not to answer)

j. Fever/chills (where a fever is typically defined as having a temp >100.4 Fahrenheit)

◯ Yes
◯ No
◯ Prefer not to answer

Date on which you first experienced symptom:

Month:

◯ January (01)
◯ February (02)
◯ March (03)
◯ April (04)
◯ May (05)
◯ June (06)
◯ July (07)
◯ August (08)
◯ September (09)
◯ October (10)
◯ November (11)
◯ December (12)
◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

Number of consecutive days you experienced symptom:	_____ (Enter "999" if prefer not to answer)
3. In the 3 weeks before you entered the study, did you seek advice from a health care professional for these symptoms? Please do not count the care you received since you entered the study.	◯ Yes ◯ No ◯ Prefer not to answer
The next set of questions are about the care you sought for these symptoms in the 3 weeks before you entered the study. a. Where did you seek care? [READ LIST]	☐ VA facility (not including this current encounter) ☐ Doctor's office (non-VA care) ☐ Emergency department (non-VA care) ☐ Telemedicine/Telephone triage (non-VA care) ☐ Health department/Public health clinic ☐ Retail clinic/Pharmacy ☐ Urgent care (non-VA care) ☐ Other ☐ Prefer not to answer
b. How long after your symptoms started did you seek care? [READ LIST]	◯ Less than 2 days ◯ 2-7 days ◯ Greater than 1 week ◯ Prefer not to answer
4. In the 3 weeks before you entered the study, did doctors use a laboratory test to check if you had influenza (Flu)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
5. In the 3 weeks before you entered the study, had you been diagnosed with COVID-19? [IF YES READ LIST]	◯ Yes, confirmed by a positive laboratory test ◯ Yes, suspected by a doctor but not confirmed by a test ◯ No ◯ Prefer not to answer
6. Do you know what type of laboratory test you had for COVID-19? [READ LIST]	◯ Yes, by nasal swab (PCR) ◯ Yes, by blood test (antibody) ◯ Yes, by another test ◯ Don't know ◯ Prefer not to answer
7. Is there a suspected source of your COVID-19? [READ LIST] [If the person reports multiple sources, ask if the suspect source(s) were confirmed by a public health "contact tracer" and that option would take precedent over non-confirmed exposures. However, if the person states multiple suspect sources without confirmation by contact tracing, mark all self-reported sources the respondent indicates.]	◯ Travel related ◯ Family member was sick ◯ Coworker or other work contact was sick ◯ Friend or other social contact was sick ◯ Don't know ◯ Prefer not to answer

This section asks about any COVID-19 hospitalizations and treatments you have ever received prior to entering into this study. We are interested in past hospitalizations or treatments. This does not include any care you are currently receiving from the VA.

8. Prior to entering this study, were you ever hospitalized for treatment of COVID-19? [IF HOSPITALIZED MORE THAN ONCE, WE ARE INTERESTED IN THE FIRST HOSPITALIZATION.]

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

9. Were you hospitalized at a VA facility?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

10. What date were you admitted to the hospital for treatment of COVID-19?

Month:

- ◯ January (01)
- ◯ February (02)
- ◯ March (03)
- ◯ April (04)
- ◯ May (05)
- ◯ June (06)
- ◯ July (07)
- ◯ August (08)
- ◯ September (09)
- ◯ October (10)
- ◯ November (11)
- ◯ December (12)
- ◯ Prefer not to answer

Day:

_____

(DDEnter "999" if prefer not to answer)

Year:

_____

(YYYYEnter "999" if prefer not to answer)

11. What date were you discharged from the hospital after treatment of COVID-19?

Month:

- ◯ January (01)
- ◯ February (02)
- ◯ March (03)
- ◯ April (04)
- ◯ May (05)
- ◯ June (06)
- ◯ July (07)
- ◯ August (08)
- ◯ September (09)
- ◯ October (10)
- ◯ November (11)
- ◯ December (12)
- ◯ Prefer not to answer

Day:

_____

(DDEnter "999" if prefer not to answer)

Year:	_____ (YYYYEnter "999" if prefer not to answer)
12. Did you require a breathing tube through the mouth for respiratory support while in the hospital (intubation/mechanical ventilation/respirator)?	◯ Yes ◯ No ◯ Prefer not to answer
13. Were you hospitalized in an Intensive Care Unit (ICU) for treatment of COVID-19?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
14. Did you receive respiratory support at home to treat your COVID 19, such as oxygen therapy by nasal prong or facemask or CPAP machine?	◯ Yes ◯ No ◯ Prefer not to answer
15. For how long did you need respiratory support at home?	_____ (DaysEnter "999" if prefer not to answer)
INTERVIEWER: WOULD YOU LIKE TO PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE?	◯ Yes ◯ No
INTERVIEWER: PLEASE PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE.	_____ (Do not enter identifiable information into notes box.)
CLICK "NOW" BUTTON TO ENTER MODULE END DATE & TIME.	_____

MVP COVID-19 Survey Module 3

MODULE 3: COVID-19 IMPACT BEHAVIOR/WELL-BEING

CLICK "NOW" BUTTON TO ENTER MODULE START DATE & TIME.

_____

This section asks questions about your behaviors and well-being in the 6 months before your symptoms started. We are interested in the symptoms that lead to your participating in this study and the impact it has had on you.

1. Which of the following have you done in the 6 months before your symptoms started? Please answer Yes or No to each item. [READ LIST]

- ☐ Used a face mask or other face covering while in public
- ☐ Used gloves while in public
- ☐ Washed your hands with soap or used hand sanitizer several times a day
- ☐ Cleaned high touch surfaces like door handles, counters, faucets, and remote controls
- ☐ Practiced social distancing (avoiding contact with anyone outside of the home)
- ☐ Avoided contact with people who could be high-risk
- ☐ Avoided eating at restaurants
- ☐ Avoided public spaces, gatherings, or crowds
- ☐ Avoided gatherings of more than 50 people
- ☐ Cancelled doctor's appointments
- ☐ Prefer not to answer

2. During the 6 months before your symptoms started, have any of the following aspects of your life changed? For each item I list, please indicate whether it has decreased, stayed the same, increased, or is not applicable. [REPEAT OPTIONS AS NECESSARY]

a. Amount you sleep

- ◯ Decreased
- ◯ Stayed the same
- ◯ Increased
- ◯ Not applicable
- ◯ Prefer not to answer

b. Amount of physical activity you do

- ◯ Decreased
- ◯ Stayed the same
- ◯ Increased
- ◯ Not applicable
- ◯ Prefer not to answer

c. Amount you smoke/vape

- ◯ Decreased
- ◯ Stayed the same
- ◯ Increased
- ◯ Not applicable
- ◯ Prefer not to answer

d. Amount of alcohol you drink

- ◯ Decreased
- ◯ Stayed the same
- ◯ Increased
- ◯ Not applicable
- ◯ Prefer not to answer

e. Number of hours you work in usual workplace	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
f. Number of hours you work at home	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
g. Time spent talking to family/friends	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
h. Time spent talking to work colleagues	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
i. Practicing relaxation/mindfulness/meditation	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
j. Time watching TV/streaming services	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
k. Time spent reading or listening to the news	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
l. Time spent on social media	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
m. Time spent playing video games	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer
n. Time spent doing hobbies/things you enjoy	◯ Decreased ◯ Stayed the same ◯ Increased ◯ Not applicable ◯ Prefer not to answer

o. Amount you eat

- ◯ Decreased
- ◯ Stayed the same
- ◯ Increased
- ◯ Not applicable
- ◯ Prefer not to answer

p. Amount of money you've spent

- ◯ Decreased
- ◯ Stayed the same
- ◯ Increased
- ◯ Not applicable
- ◯ Prefer not to answer

3. In the 6 months before your symptoms started, have you been bothered by any of these problems?

For each item I will list, please select between the following responses: not at all, several days, more days than not, and nearly every day. [REPEAT OPTIONS AS NECESSARY]

a. Feeling nervous, anxious, or on edge

- ◯ Not at all
- ◯ Several days
- ◯ More days than not
- ◯ Nearly every day
- ◯ Prefer not to answer

b. Not being able to stop or control worrying

- ◯ Not at all
- ◯ Several days
- ◯ More days than not
- ◯ Nearly every day
- ◯ Prefer not to answer

c. Feeling down, depressed, or hopeless

- ◯ Not at all
- ◯ Several days
- ◯ More days than not
- ◯ Nearly every day
- ◯ Prefer not to answer

d.Â Little interest or pleasure in doing things

- ◯ Not at all
- ◯ Several days
- ◯ More days than not
- ◯ Nearly every day
- ◯ Prefer not to answer

4. The next set of questions asks about social isolation in the 6 months before your symptoms started. I will read you a list of statements; for each of the statements please select the best choice that describes how you feel: Never, Rarely, Sometimes, Usually, Always, and Don't know or not applicable. In the 6 months before your symptoms started, [READ ITEM THEN LIST OPTIONS AND REPEAT RESPONSE OPTIONS AS NEEDED; Select only one response for each question or statement.]

SOCIAL ISOLATION

a. I feel left out...

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

b. I feel that people barely know me...
- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

c. I feel isolated from others...
- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

d. I feel that people are around me, but not with me...
- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

5. The next set of questions asks about emotional support in the 6 months before your symptoms started. I will read you a list of statements; for each of the statements please select the best choice that describes how you feel: Never, Rarely, Sometimes, Usually, Always, and Don't know or not applicable.

During the 6 months before your symptoms started, [READ ITEM THEN LIST OPTIONS AND REPEAT RESPONSE OPTIONS AS NEEDED; Select only one response for each question or statement.]

EMOTIONAL SUPPORT

a. I have someone who will listen to me when I need to talk.
- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

b. I have someone to confide in or talk to about myself or my problems.
- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

c. I have someone who makes me feel appreciated.
- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

d. I have someone to talk with when I have a bad day.

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Usually
- ◯ Always
- ◯ Don't know or N/A
- ◯ Prefer not to answer

6. For the next set of questions, I will read you a list of statements. For each of the statements please select the best choice that describes how you feel in the 6 months before your symptoms started: No loss, minimal loss, noticeable loss, extreme loss, or don't know/not applicable. How has/have [ITEM] been impacted since the pandemic? [REPEAT RESPONSE OPTIONS AS NEEDED; Select only one response for each question or statement.]

a. Adequate food

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

b. Your residence/home you live in

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

c. Things you need for your children or members of your household

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

d. Money for extras

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

e. Savings or emergency money

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

f. Adequate income

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

g. Financial credit	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
h. Your retirement security	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
i. Free time	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
j. Time for enough sleep	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
k. Feeling valuable to other people	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
l. A feeling of intimacy with one or more family members	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
m. The feeling that you're accomplishing the goals in your life	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
n. Time with your loved ones	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer

o. The sense of a daily routine

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

p. Health of a family member/friend

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

q. Stable employment

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

r. Ability to organize tasks

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

s. Time needed to do your work

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

t. Understanding from your boss

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

u. Support from your co-workers

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

v. The chance to get more training or education

- ◯ No loss
- ◯ Minimal loss
- ◯ Noticeable loss
- ◯ Extreme loss
- ◯ Don't know or N/A
- ◯ Prefer not to answer

w. Feeling of being independent	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
x. Companionship with others	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
y. Feeling that your life has meaning or purpose	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
z. Involvement with your church	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
aa. Help with tasks at home	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
bb. Loyalty of friends	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
cc. Help with childcare	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
dd. Involvement in organizations or clubs	◯ No loss ◯ Minimal loss ◯ Noticeable loss ◯ Extreme loss ◯ Don't know or N/A ◯ Prefer not to answer
INTERVIEWER: WOULD YOU LIKE TO PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE?	◯ Yes ◯ No

INTERVIEWER: PLEASE PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE.

_____

(Do not enter identifiable information into notes box.)

CLICK "NOW" BUTTON TO ENTER MODULE END DATE & TIME.

_____

MVP COVID-19 Survey Module 4

MODULE 4: DEMOGRAPHICS

CLICK "NOW" BUTTON TO ENTER MODULE START DATE & TIME.

_____

1. What is your date of birth?

Month:

- ◯ January (01)
- ◯ February (02)
- ◯ March (03)
- ◯ April (04)
- ◯ May (05)
- ◯ June (06)
- ◯ July (07)
- ◯ August (08)
- ◯ September (09)
- ◯ October (10)
- ◯ November (11)
- ◯ December (12)
- ◯ Prefer not to answer

Day:

_____
(DDEnter "999" if prefer not to answer)

Year:

_____
(YYYYEnter "999" if prefer not to answer)

2. What is your gender? [READ LIST]

- ◯ Male
- ◯ Female
- ◯ Prefer not to answer

3. Are you Spanish, Hispanic, or Latino?

- ◯ Yes
- ◯ No, not Spanish, Hispanic, Latino
- ◯ Prefer not to answer

Which best describes your background? [READ LIST]

- ◯ Yes, Mexican, Mexican American, Chicano
- ◯ Yes, Puerto Rican
- ◯ Yes, Cuban
- ◯ Yes, other Spanish, Hispanic, Latino
- ◯ Prefer not to answer

4. What is your race? I'm going to read a list and I will mark all that apply.

IF ASKED:

- Asian Indian: This means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Thailand, and Vietnam.

- Original peoples: "Original peoples" are ethnic groups who are the original or earliest known inhabitants of an area.

- Filipino: This refers to a person having origins in the original people from the Philippine Islands.

☐ White
☐ Black / African American
☐ American Indian / Alaska Native
☐ Chinese
☐ Japanese
☐ Asian Indian
☐ Filipino
☐ Pacific Islander
☐ Other
☐ Prefer not to answer

5. What is your highest degree or level of school you have completed? IF NEEDED, READ LEVEL/DEGREES

◯ Less than high school
◯ High school diploma / GED
◯ Some college credit, but no degree
◯ Associate's degree (e.g., AA, AS)
◯ Bachelor's degree (e.g., BA, BS)
◯ Master's degree (e.g., MA, MS, MBA)
◯ Professional or Doctorate degree
◯ Prefer not to answer

6. What is your current marital status? [READ LIST]

◯ Married
◯ Civil commitment
◯ Cohabitating
◯ Separated
◯ Divorced
◯ Widowed
◯ Never married
◯ Prefer not to answer

7. Including yourself, how many people currently live in your household?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9+
◯ Prefer not to answer

8. Which income category represents the total income of your household from all sources (before taxes and deductions) during the last 12 months? [READ LIST AND STOP WHEN CATEGORY REACHED OR RESPONDENT GIVES ANSWER.]

◯ Less than $10,000
◯ $10,000 - $19,999
◯ $20,000 - $29,999
◯ $30,000 - $39,999
◯ $40,000 - $49,999
◯ $50,000 - $59,999
◯ $60,000 - $74,999
◯ $75,000 - $99,999
◯ $100,000 - $149,999
◯ $150,000 or more
◯ Prefer not to answer

9. What is your height in feet and inches?

Feet:	_____ (Enter "999" if prefer not to answer)
Inches:	_____ (Enter "999" if prefer not to answer)
10. What is your weight in pounds?	_____ (PoundsEnter "999" if prefer not to answer)
11. In which branch of the service did you serve? [READ ENTIRE LIST]	☐ Army ☐ Navy ☐ Air Force ☐ Coast Guard ☐ Marine Corps ☐ National Guard ☐ Merchant Marines ☐ NOAA ☐ Public Health Services ☐ None ☐ Prefer not to answer
12. Please indicate whether your service was: [READ LIST]	◯ Active duty ◯ Reserves only ◯ Not applicable (not in the military) ◯ Prefer not to answer
13. When did you serve? [READ LIST AND CHECK ALL THAT APPLY]	☐ September 2001 or later ☐ August 1990 to August 2001 (includes Gulf War) ☐ May 1975 to July 1990 ☐ August 1964 to April 1975 (Vietnam era) ☐ February 1955 to July 1964 ☐ July 1950 to January 1955 (Korean War) ☐ January 1947 to June 1950 ☐ December 1941 to December 1946 (WWII) ☐ November 1941 or earlier ☐ Prefer not to answer
14. How often do you have a drink containing alcohol? [READ LIST]	◯ Never ◯ 1-3 days per month ◯ 1 day per week ◯ 2-3 days per week ◯ 4-5 days per week ◯ 6 or more days per week ◯ Prefer not to answer
15. How many drinks containing alcohol do you have on a typical day when you are drinking? [READ OPTIONS IF NEEDED]	◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more ◯ Prefer not to answer

16. How often do you have six or more drinks on one occasion? [READ LIST]	◯ Never ◯ Less than monthly ◯ Monthly ◯ 2-3 times per week ◯ 4 or more times per week ◯ Prefer not to answer
17. In your lifetime have you ever smoked a total of at least 100 cigarettes, cigars, or pipes?	◯ Yes ◯ No ◯ Prefer not to answer
18. Have you ever smoked daily or almost every day for at least one year?	◯ Yes ◯ No ◯ Prefer not to answer
19. Thinking of the 3 weeks before you entered the study, did you smoke? [READ LIST]	◯ Yes, daily ◯ Yes, occasionally ◯ Not at all ◯ Prefer not to answer
20. Do you smoke now? [READ LIST]	◯ Yes, daily ◯ Yes, occasionally ◯ Not at all ◯ Prefer not to answer
The following questions concern electronic vaping products for nicotine use. Do not include marijuana use. 21. Have you ever used an e-cigarette or other electronic vaping product, even just one time, in your entire life? [READ OPTIONS IF NEEDED]	◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know
22. In the 3 weeks before you entered the study, did you use e-cigarettes or other electronic vaping products every day, some days, or not at all? [READ OPTIONS]	◯ Every day ◯ Some days ◯ Not at all ◯ Prefer not to answer ◯ Don't know
23. Do you NOW use e-cigarettes or other electronic vaping products every day, some days, or not at all? [READ OPTIONS]	◯ Every day ◯ Some days ◯ Not at all ◯ Prefer not to answer ◯ Don't know
INTERVIEWER: WOULD YOU LIKE TO PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE?	◯ Yes ◯ No
INTERVIEWER: PLEASE PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE.	_____ (Do not enter identifiable information into notes box.)
CLICK "NOW" BUTTON TO ENTER MODULE END DATE & TIME.	_____

MVP COVID-19 Survey Module 5

MODULE 5: MEDICAL CONDITIONS/COMORBIDITY

CLICK "NOW" BUTTON TO ENTER MODULE START DATE & TIME. _____

This section asks about medical conditions before you entered the study.

1. We'd like to ask about your general health. Please tell us if you have ever been diagnosed with the following conditions.

[IF YES TO CONDITION, ASK:] In what year were you diagnosed? Do you currently take any medications for this condition?

CIRCULATORY SYSTEM PROBLEMS

High blood pressure (Hypertension)
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

High blood pressure (Hypertension) YEAR DIAGNOSED
_____
(YYYYEnter "999" if prefer not to answer)

High blood pressure (Hypertension) TAKE MEDS
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Stroke
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Stroke YEAR DIAGNOSED
_____
(YYYYEnter "999" if prefer not to answer)

Stroke TAKE MEDS
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Transient ischemic attack (TIA)
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Transient ischemic attack (TIA) YEAR DIAGNOSED
_____
(YYYYEnter "999" if prefer not to answer)

Transient ischemic attack (TIA) TAKE MEDS
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Heart attack	◯ Yes ◯ No ◯ Prefer not to answer
Heart attack YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Heart attack TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Coronary artery / Coronary heart disease (includes angina)	◯ Yes ◯ No ◯ Prefer not to answer
Coronary artery / Coronary heart disease (includes angina) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Coronary artery / Coronary heart disease (includes angina) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Peripheral vascular disease	◯ Yes ◯ No ◯ Prefer not to answer
Peripheral vascular disease YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Peripheral vascular disease TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
High cholesterol	◯ Yes ◯ No ◯ Prefer not to answer
High cholesterol YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
High cholesterol TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Pulmonary embolism or deep vein thrombosis (DVT)	◯ Yes ◯ No ◯ Prefer not to answer
Pulmonary embolism or deep vein thrombosis (DVT) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)

Pulmonary embolism or deep vein thrombosis (DVT) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Congestive heart failure	◯ Yes ◯ No ◯ Prefer not to answer
Congestive heart failure YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Congestive heart failure TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other circulatory system problem	◯ Yes ◯ No ◯ Prefer not to answer
Other circulatory system problem YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other circulatory system problem TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
SKELETAL / MUSCULAR PROBLEMS	
Osteoarthritis	◯ Yes ◯ No ◯ Prefer not to answer
Osteoarthritis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Osteoarthritis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Rheumatoid arthritis	◯ Yes ◯ No ◯ Prefer not to answer
Rheumatoid arthritis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Rheumatoid arthritis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other arthritis	◯ Yes ◯ No ◯ Prefer not to answer

Other arthritis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other arthritis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Gout	◯ Yes ◯ No ◯ Prefer not to answer
Gout YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Gout TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Osteoporosis	◯ Yes ◯ No ◯ Prefer not to answer
Osteoporosis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Osteoporosis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other skeletal / muscular problem	◯ Yes ◯ No ◯ Prefer not to answer
Other skeletal / muscular problem YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other skeletal / muscular problem TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
MENTAL HEALTH DISORDERS	
Anxiety reaction / Panic disorder	◯ Yes ◯ No ◯ Prefer not to answer
Anxiety reaction / Panic disorder YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Anxiety reaction / Panic disorder TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer

Attention deficit hyper-activity disorder (ADHD)	◯ Yes ◯ No ◯ Prefer not to answer
Attention deficit hyper-activity disorder (ADHD) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Attention deficit hyper-activity disorder (ADHD) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Bipolar disorder	◯ Yes ◯ No ◯ Prefer not to answer
Bipolar disorder YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Bipolar disorder TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Post-traumatic stress disorder (PTSD)	◯ Yes ◯ No ◯ Prefer not to answer
Post-traumatic stress disorder (PTSD) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Post-traumatic stress disorder (PTSD) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Depression	◯ Yes ◯ No ◯ Prefer not to answer
Depression YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Depression TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Eating disorder	◯ Yes ◯ No ◯ Prefer not to answer
Eating disorder YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)

Eating disorder TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Personality disorder	◯ Yes ◯ No ◯ Prefer not to answer
Personality disorder YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Personality disorder TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Schizophrenia	◯ Yes ◯ No ◯ Prefer not to answer
Schizophrenia YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Schizophrenia TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Social phobia	◯ Yes ◯ No ◯ Prefer not to answer
Social phobia YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Social phobia TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other mental health disorder	◯ Yes ◯ No ◯ Prefer not to answer
Other mental health disorder YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other mental health disorder TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
HEARING / VISION	
Cataracts	◯ Yes ◯ No ◯ Prefer not to answer

Cataracts YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Cataracts TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Glaucoma	◯ Yes ◯ No ◯ Prefer not to answer
Glaucoma YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Glaucoma TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Macular degeneration	◯ Yes ◯ No ◯ Prefer not to answer
Macular degeneration YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Macular degeneration TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Blindness, all causes	◯ Yes ◯ No ◯ Prefer not to answer
Blindness, all causes YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Blindness, all causes TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Tinnitus or ringing in the ears	◯ Yes ◯ No ◯ Prefer not to answer
Tinnitus or ringing in the ears YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Tinnitus or ringing in the ears TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer

Severe hearing loss or partial deafness in one or both ears	◯ Yes ◯ No ◯ Prefer not to answer
Severe hearing loss or partial deafness in one or both ears YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Severe hearing loss or partial deafness in one or both ears TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
INFECTIOUS DISEASES	
Tuberculosis	◯ Yes ◯ No ◯ Prefer not to answer
Tuberculosis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Tuberculosis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Hepatitis C	◯ Yes ◯ No ◯ Prefer not to answer
Hepatitis C YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Hepatitis C TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
HIV / AIDS	◯ Yes ◯ No ◯ Prefer not to answer
HIV / AIDS YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
HIV / AIDS TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other infectious disease	◯ Yes ◯ No ◯ Prefer not to answer
Other infectious disease YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)

Other infectious disease TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
KIDNEY DISEASE	
Kidney disease without dialysis	◯ Yes ◯ No ◯ Prefer not to answer
Kidney disease without dialysis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Kidney disease without dialysis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Kidney disease with dialysis	◯ Yes ◯ No ◯ Prefer not to answer
Kidney disease with dialysis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Kidney disease with dialysis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Acute kidney disease with no current dialysis	◯ Yes ◯ No ◯ Prefer not to answer
Acute kidney disease with no current dialysis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Acute kidney disease with no current dialysis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
DIGESTIVE SYSTEM PROBLEMS	
Acid reflux / GERD	◯ Yes ◯ No ◯ Prefer not to answer
Acid reflux / GERD YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Acid reflux / GERD TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer

Peptic ulcers	◯ Yes ◯ No ◯ Prefer not to answer
Peptic ulcers YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Peptic ulcers TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Bowel obstruction	◯ Yes ◯ No ◯ Prefer not to answer
Bowel obstruction YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Bowel obstruction TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Colon polyps	◯ Yes ◯ No ◯ Prefer not to answer
Colon polyps YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Colon polyps TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Irritable bowel syndrome (IBS)	◯ Yes ◯ No ◯ Prefer not to answer
Irritable bowel syndrome (IBS) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Irritable bowel syndrome (IBS) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Ulcerative colitis	◯ Yes ◯ No ◯ Prefer not to answer
Ulcerative colitis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)

Ulcerative colitis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Crohn's disease	◯ Yes ◯ No ◯ Prefer not to answer
Crohn's disease YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Crohn's disease TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Celiac disease / Sprue	◯ Yes ◯ No ◯ Prefer not to answer
Celiac disease / Sprue YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Celiac disease / Sprue TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other digestive system disorder	◯ Yes ◯ No ◯ Prefer not to answer
Other digestive system disorder YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other digestive system disorder TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
CANCER	
Breast cancer	◯ Yes ◯ No ◯ Prefer not to answer
Breast cancer YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Breast cancer TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Colon cancer / Rectal cancer	◯ Yes ◯ No ◯ Prefer not to answer

Colon cancer / Rectal cancer YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Colon cancer / Rectal cancer TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Lung cancer	◯ Yes ◯ No ◯ Prefer not to answer
Lung cancer YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Lung cancer TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Prostate cancer	◯ Yes ◯ No ◯ Prefer not to answer
Prostate cancer YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Prostate cancer TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Skin cancer	◯ Yes ◯ No ◯ Prefer not to answer
Skin cancer YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Skin cancer TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other cancer	◯ Yes ◯ No ◯ Prefer not to answer
Other cancer YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other cancer TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
NERVOUS SYSTEM PROBLEMS	

Migraine headaches	◯ Yes ◯ No ◯ Prefer not to answer
Migraine headaches YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Migraine headaches TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other headaches	◯ Yes ◯ No ◯ Prefer not to answer
Other headaches YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other headaches TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Memory loss or impairment	◯ Yes ◯ No ◯ Prefer not to answer
Memory loss or impairment YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Memory loss or impairment TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Dementia (includes Alzheimer's, vascular, etc.)	◯ Yes ◯ No ◯ Prefer not to answer
Dementia (includes Alzheimer's, vascular, etc.) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Dementia (includes Alzheimer's, vascular, etc.) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Concussion or loss of consciousness	◯ Yes ◯ No ◯ Prefer not to answer
Concussion or loss of consciousness YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)

Concussion or loss of consciousness TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Traumatic brain injury	◯ Yes ◯ No ◯ Prefer not to answer
Traumatic brain injury YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Traumatic brain injury TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Spinal cord injury or impairment	◯ Yes ◯ No ◯ Prefer not to answer
Spinal cord injury or impairment YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Spinal cord injury or impairment TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Epilepsy / Seizure	◯ Yes ◯ No ◯ Prefer not to answer
Epilepsy / Seizure YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Epilepsy / Seizure TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Parkinson's disease	◯ Yes ◯ No ◯ Prefer not to answer
Parkinson's disease YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Parkinson's disease TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Amyotrophic lateral sclerosis (Lou Gehrig's disease)	◯ Yes ◯ No ◯ Prefer not to answer

Amyotrophic lateral sclerosis (Lou Gehrig's disease) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Amyotrophic lateral sclerosis (Lou Gehrig's disease) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Multiple sclerosis	◯ Yes ◯ No ◯ Prefer not to answer
Multiple sclerosis YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Multiple sclerosis TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other nervous system problem	◯ Yes ◯ No ◯ Prefer not to answer
Other nervous system problem YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Other nervous system problem TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
OTHER CONDITIONS	
Asthma	◯ Yes ◯ No ◯ Prefer not to answer
Asthma YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Asthma TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Chronic lung disease (COPD, Emphysema or Bronchitis)	◯ Yes ◯ No ◯ Prefer not to answer
Chronic lung disease (COPD, Emphysema or Bronchitis) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Chronic lung disease (COPD, Emphysema or Bronchitis) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer

Diabetes / "sugar"	◯ Yes ◯ No ◯ Prefer not to answer
Diabetes / "sugar" YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Diabetes / "sugar" TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Enlarged prostate (Benign prostatic hyperplasia)	◯ Yes ◯ No ◯ Prefer not to answer
Enlarged prostate (Benign prostatic hyperplasia) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Enlarged prostate (Benign prostatic hyperplasia) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Liver condition (e.g., Cirrhosis)	◯ Yes ◯ No ◯ Prefer not to answer
Liver condition (e.g., Cirrhosis) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Liver condition (e.g., Cirrhosis) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Skin condition (e.g., Eczema, Psoriasis)	◯ Yes ◯ No ◯ Prefer not to answer
Skin condition (e.g., Eczema, Psoriasis) YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Skin condition (e.g., Eczema, Psoriasis) TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Sleep apnea	◯ Yes ◯ No ◯ Prefer not to answer
Sleep apnea YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)

Sleep apnea TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Thyroid problems	◯ Yes ◯ No ◯ Prefer not to answer
Thyroid problems YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Thyroid problems TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Gulf War Illness/Syndrome	◯ Yes ◯ No ◯ Prefer not to answer
Gulf War Illness/Syndrome YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Gulf War Illness/Syndrome TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Chronic Fatigue Syndrome	◯ Yes ◯ No ◯ Prefer not to answer
Chronic Fatigue Syndrome YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Chronic Fatigue Syndrome TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Fibromyalgia	◯ Yes ◯ No ◯ Prefer not to answer
Fibromyalgia YEAR DIAGNOSED	_____ (YYYYEnter "999" if prefer not to answer)
Fibromyalgia TAKE MEDS	◯ Yes ◯ No ◯ Prefer not to answer
Other disease / disorder	◯ Yes ◯ No ◯ Prefer not to answer

Other disease / disorder YEAR DIAGNOSED

_____
(YYYYEnter "999" if prefer not to answer)

Other disease / disorder TAKE MEDS

◯ Yes
◯ No
◯ Prefer not to answer

2. Did you receive the following vaccines while in the military? Please answer yes or no to the best of your ability. [IF YES TO VACCINE] what year was the last vaccine dose?

Anthrax

◯ Yes
◯ No
◯ Don't Know
◯ Prefer not to answer

Year vaccinated:

_____
(YYYYEnter "999" if prefer not to answer)

Small pox

◯ Yes
◯ No
◯ Don't Know
◯ Prefer not to answer

Year vaccinated:

_____
(YYYYEnter "999" if prefer not to answer)

Rabies

◯ Yes
◯ No
◯ Don't Know
◯ Prefer not to answer

Year vaccinated:

_____
(YYYYEnter "999" if prefer not to answer)

Yellow Fever

◯ Yes
◯ No
◯ Don't Know
◯ Prefer not to answer

Year vaccinated:

_____
(YYYYEnter "999" if prefer not to answer)

Typhoid

◯ Yes
◯ No
◯ Don't Know
◯ Prefer not to answer

Year vaccinated:

_____
(YYYYEnter "999" if prefer not to answer)

Japanese Encephalitis	◯ Yes ◯ No ◯ Don't Know ◯ Prefer not to answer
Year vaccinated:	_____ (YYYYEnter "999" if prefer not to answer)
There are just a few more questions left. 3. In the PAST YEAR, have you received health care that was paid for by any of the following insurance types (excluding this current hospitalization or your most recent VA encounter)? Please answer yes or no to the best of your ability. [READ LIST, MARK IF YES]	☐ Private insurance ☐ TRICARE ☐ Medicare ☐ Medicaid ☐ Veterans Choice Program ☐ VA health care ☐ Indian Health ☐ Prefer not to answer
4. In the PAST YEAR, about how much of your health care did you get at a VA facility (e.g., doctor's visits, hospitalizations, urgent care visits, or counseling, excluding this current hospitalization or your most recent VA encounter)? [READ LIST]	◯ None ◯ 1 - 25% ◯ 26 - 50% ◯ 51 - 75% ◯ 76 - 99% ◯ 100% ◯ Prefer not to answer
5. In the PAST YEAR, how many times were you a patient in a hospital overnight or longer (excluding this current hospitalization or your most recent VA encounter)?	
In a VA Facility [READ LIST]	◯ None ◯ 1 - 3 ◯ 4 - 6 ◯ 7 - 9 ◯ 10 or more ◯ Prefer not to answer
In a Non-VA Healthcare Facility [READ LIST]	◯ None ◯ 1 - 3 ◯ 4 - 6 ◯ 7 - 9 ◯ 10 or more ◯ Prefer not to answer
6. How many prescription medications do you currently receive from:	
A VA Pharmacy [READ LIST]	◯ None ◯ 1 - 3 ◯ 4 - 6 ◯ 7 - 9 ◯ 10 or more ◯ Prefer not to answer
A Non-VA Pharmacy [READ LIST]	◯ None ◯ 1 - 3 ◯ 4 - 6 ◯ 7 - 9 ◯ 10 or more ◯ Prefer not to answer

7. How many non-prescription medications do you currently receive from:

A VA Pharmacy [READ LIST]	◯ None ◯ 1 - 3 ◯ 4 - 6 ◯ 7 - 9 ◯ 10 or more ◯ Prefer not to answer
A Non-VA Pharmacy [READ LIST]	◯ None ◯ 1 - 3 ◯ 4 - 6 ◯ 7 - 9 ◯ 10 or more ◯ Prefer not to answer

That concludes this one-time baseline questionnaire! Thank you so much for all your time, I know it's valuable and we appreciate it. Are there any remaining questions you have that I can help answer?

[IF YES, ANSWER QUESTIONS]
[IF NO, END THE CALL]

INTERVIEWER: WOULD YOU LIKE TO PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE?	◯ Yes ◯ No
INTERVIEWER: PLEASE PROVIDE ANY COMMENTS ABOUT THE COMPLETION OF THIS MODULE.	_____ (Do not enter identifiable information into notes box.)
CLICK "NOW" BUTTON TO ENTER MODULE END DATE & TIME.	_____