

Participant Health Status Form

This health status form should be completed with participants to check-in on their general health and well-being and to specifically inquire about significant respiratory illnesses that they have experienced since January 1, 2020 that may be COVID-19-related. If the participant is under 18, or requires assistance from a caregiver, the interview will need to be conducted with the participant's caregiver. In this case, please complete the Caregiver Proxy Health Status form instead to document responses for the participant.

If the caregiver is enrolled in PHACS, and would like to answer these questions about their own health, complete this form with the caregiver.

The questions in this questionnaire form (Illume) should be asked of any participant, age 18 and over, enrolled in a PHACS Study. Please enter the participant's PID, the date you made contact with this participant, and your PHACS site number.

Participant Number (PID):

Date of participant contact (mm/dd/yyyy):

PHACS Site Number:

Contact Information

1. Were you able to make contact with the participant? (1-Yes, 2-No)

If No, complete 1a and STOP.

If Yes, continue.

If you made contact with caregiver, fill out the Caregiver Proxy Health Status form.

a. Specify why no contact was made: _____

2. How did you make contact with the participant?

If 1-4, go to question 3.

If 5, STOP.

If 9, complete 'a' and continue.

- 1-Telephone
- 2-In Clinic
- 3-FaceTime or Video conference
- 4-Telehealth
- 5-Contact made but did not speak to the participant, (e.g. text, email)
- 9-Other

a. If Other, please specify: _____

Health Status

READ: Now I would like to ask you some more questions about your health. I will be asking you a series of questions about respiratory illnesses and symptoms you may have had.

General Health

3. I'd like to start off by checking in on your health status over the last two weeks. In general, how would you say your health has been over the last two weeks?

If 6, STOP.

If 7 or 9, go to question 5.

1-Excellent

2-Very good

3-Good

4-Fair

5-Poor

6-Participant unable to respond (no time or privacy)

7-Participant declined to answer

9-Unknown

4. Is this better, worse, or the same, than before the pandemic started?
(1-Better, 2-Worse, 3-Same, 4-Unknown)

READ: The next few questions ask about a respiratory illness that has been affecting people, called coronavirus. You may have also heard coronavirus called COVID-19 or SARS-CoV-2. We want to understand how this pandemic has affected you.

5. I would like to talk with you more about how you are doing, and ask you some questions about COVID-19 and other respiratory illnesses that may have affected you. Do you have 15-20 minutes and a private place to talk further? (1-Yes, 2-No)

If No, ask the participant if you can contact them at a later time, then go to question 35.

Document in question 35 if the participant will allow you to contact them at a later time.

If Yes, continue.

COVID-Related

NOTE TO INTERVIEWER: In this next question, please provide examples of what would classify as "worse than the common cold." Examples of a common cold include a runny nose, sneezing, sometimes a sore throat, and no fever.

6. Since January 1, 2020, have you had any respiratory illnesses that were worse than the common cold? (1-Yes, 2-No)

If No, go to Section B and complete.

If Yes, complete 6a, then go to Section A, and complete.

a. How many respiratory illnesses did you have since January 1, 2020 that were worse than the common cold? (Indicate number)

SECTION A: The following questions (7-24) will be asked for each respiratory illness individually. Illume will allow for data entry for each illness (if > 1).

7. When did the respiratory illness begin? Please use your best guess.

Month (mm): Year (yyyy):

8. Did the illness begin at the beginning of the month, the middle of the month or the end of the month?
(1-Beginning, 2-Middle, 3-End, 4-Unknown)

READ: I am going to ask you questions about the illness that occurred in (specify month/year).

9. Do you know the number of days that this respiratory illness lasted? (1-Yes, 2-No)

If Yes complete 'a' and go to question 10.

If No, complete 'b' and go to question 10.

a. How long did this respiratory illness last? (Number of days)

b. Please estimate the length of your respiratory illness using these time periods?

- 1- Less than 1 week
- 2- Between 1-2 weeks
- 3- More than 2 weeks
- 4- Don't know

10. Overall, did you feel that this respiratory illness was mild, moderate or severe?
(1-Mild, 2-Moderate, 3-Severe)

11. Did you have any of the following symptoms during this respiratory illness?

NOTE TO INTERVIEWER: If the participant says “Yes” to having any of the symptoms below, please ask the participant to rank the severity as Mild, Moderate or Severe.

Symptom	Please answer Yes or No to each (1-Yes, 2-No).	If Yes, please indicate Mild, Moderate or Severe for each.		
		Mild	Moderate	Severe
Fever. If yes, record the highest temperature (°F) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough with sputum (mucus) production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry cough without sputum (mucus) production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red eyes or conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other. Please specify the other symptom _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Did you discuss your respiratory illness with any healthcare provider by phone, text, email, Telehealth, a COVID-19 hotline staffed by healthcare personnel, etc?
If 1, 3, or 4 complete 'a' and continue.
If 2, go to question 13.

- 1-Yes
- 2-No
- 3-Attempted to contact the healthcare facility/provider but was unable to make contact with anyone
- 4-Contacted the healthcare facility/provider but no health care professional was available

a. Please list the name of the healthcare provider/facility that you contacted or attempted to contact.

Healthcare provider/facility name: _____

13. Did you go to a healthcare facility for this respiratory illness? Please check all that apply.
If No, go to question 14.
If Yes, complete 'a' and continue.

- No, did not go to a healthcare facility
- Yes; Doctor's office (Primary care clinic or office, HIV Care Clinic, OB Clinic)
- Yes; Urgent Care
- Yes, Minute Clinic
- Yes; Hospital or Emergency Department
- Yes; Telehealth visit
- Yes; Drive-through testing
- Yes; Other. Please specify: _____

a. Please list the name(s) of the healthcare facility(ies)/provider(s) that you saw:

Healthcare facility/provider name(s):
1.
2.
3.
4.
5.

14. Were you hospitalized for this respiratory illness? (1-Yes, 2-No)
If No, go to question 15.
If Yes, continue.

a. For how many days were you hospitalized? (Number of days)

15. Were you tested for **COVID-19** during this illness?
(1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)
If 1, complete 'a' then go to question 16.
If 3, complete 'b' then go to questions 16.
If 2 or 4, go to question 16.

a. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

b. Please explain why you couldn't get tested: _____

16. Were you tested for the **flu** during this illness?
(1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)
If 1, complete 'a' then go to question 17.
If 3, complete 'b' then go to question 17.
If 2 or 4, go to question 17.

a. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

b. Please explain why you couldn't get tested: _____

17. Were you tested for any **other virus** during this illness?
 (1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)
 If 1, complete 'a' and 'b' then go to question 18.
 If 3, complete 'c' then go to question 18.
 If 2 or 4, go to question 18.

a. Please specify the other virus you were tested for: _____

b. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/>	<input type="text"/>

c. Please explain why you couldn't get tested: _____

18. In the 2 weeks before your symptoms started for this respiratory illness, did anyone in your household get tested for any of the following viruses?

Virus	Tested? (1-Yes, 2-No, 3-Unknown)	If Tested, indicate result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
a. The coronavirus that causes COVID-19 (SARS-CoV-2)	<input type="text"/>	<input type="text"/>
b. Flu	<input type="text"/>	<input type="text"/>
c. Other virus, specify if known _____	<input type="text"/>	<input type="text"/>

19. In the 2 weeks before your symptoms started for this respiratory illness, did you have any close contact with a confirmed case of COVID-19 or with someone with an illness they thought might be COVID-19? (1-Yes, 2-No, 3-Unknown)

If Yes, continue.

If No or Unknown, go to question 20.

a. Was that contact feeling sick? (1-Yes, 2-No, 3-Unknown)

20. Did a healthcare provider give you any of the following medications to treat COVID-19?
Please respond with Yes, No, or Unknown for each.

Medication	1-Yes, 2-No, 3-Unknown
Lopinavir/Ritonavir (Kaletra)	<input type="checkbox"/>
Hydroxychloroquine (Plaquenil)	<input type="checkbox"/>
Hydroxychloroquine (Plaquenil) with Azithromycin (Zithromax, Z-Pak)	<input type="checkbox"/>
Chloroquine	<input type="checkbox"/>
Ribavirin (Moderiba or Rebetol)	<input type="checkbox"/>
Remdesivir	<input type="checkbox"/>
Azithromycin (Zithromax, Z-Pak)	<input type="checkbox"/>
Atorvastatin (Lipitor)	<input type="checkbox"/>
Pravastatin (Pravachol)	<input type="checkbox"/>
Sarilumab (Kevzara)	<input type="checkbox"/>
Tocilizumab (Actemra)	<input type="checkbox"/>
Other. Please specify _____	<input type="checkbox"/>

21. Are you enrolled in a treatment trial for COVID-19? (1-Yes, 2-No)

If No, go to question 22.
If Yes, complete 'a' and continue.

a. What is the name of the trial? _____

22. In the 2 weeks before your symptoms started for this respiratory illness, did you travel anywhere outside the area of your normal activities? (1-Yes, 2-No)

If No, go to question 23.
If Yes, continue.

Where did you travel? (Country, State, City, Different neighborhood)
a.
b.
c.
d.

23. You said you had at least one respiratory illness that was worse than the common cold. In addition to the illnesses that we just discussed, we want to know about any other symptoms you may have had that were not connected to the illnesses we just discussed.

NOTE TO INTERVIEWER: If the participant says “Yes” to having any of the symptoms below, please ask the participant to rank the severity as Mild, Moderate, or Severe.

Symptom	Please answer Yes or No to each (1-Yes, 2-No).	If Yes, please indicate Mild, Moderate or Severe for each.		
		Mild	Moderate	Severe
Fever. If yes, record the highest temperature (°F) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough with sputum (mucus) production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry cough without sputum (mucus) production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red eyes or conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other. Please specify the other symptom _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. I previously asked you if you were tested for COVID-19 during your respiratory illnesses.

Were you tested for **COVID-19** at any other time?
(1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)
If 1, complete 'a' then go to Section C and complete.
If 3, complete 'b' then go to Section C and complete.
If 2 or 4, go to Section C and complete.

a. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

b. Please explain why you couldn't get tested: _____

Go to SECTION C

SECTION B:

25. You said you **did not** have any respiratory illnesses that were worse than the common cold. Now I want to ask if you had any of these symptoms since January 1, 2020.

NOTE TO INTERVIEWER: If the participant says “Yes” to having any of the symptoms below, please ask the participant to rank the severity as Mild, Moderate or Severe.

Symptom	Please answer Yes or No to each (1-Yes, 2-No).	If Yes, please indicate Mild, Moderate or Severe for each.		
		Mild	Moderate	Severe
Fever. If yes, record the highest temperature (°F) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough with sputum (mucus) production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry cough without sputum (mucus) production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red eyes or conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other. Please specify the other symptom _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Were you tested for **COVID-19**? (1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)

If 1, complete 'a' then go to question 27.
If 3, complete 'b' then go to questions 27.
If 2 or 4, go to question 27.

a. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

b. Please explain why you couldn't get tested: _____

27. Were you tested for the **flu**? (1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)

If 1, complete 'a' then go to question 28.
If 3, complete 'b' then go to question 28.
If 2 or 4, go to question 28.

a. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

b. Please explain why you couldn't get tested: _____

28. Were you tested for any **other virus**? (1-Yes, 2-No, 3-Tried but couldn't get tested, 4-Unknown)

If 1, complete 'a' and 'b' then go to question 29.

If 3, complete 'c' then go to question 29.

If 2 or 4, go to question 29.

a. Please specify the other virus you were tested for: _____

b. Please provide the date(s) you were tested and the result(s) of the test:

	Date of Test (mm/dd/yyyy)	Result (1-Positive, 2-Negative, 3-Pending, 4-Unknown)
1. Test 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
2. Test 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
3. Test 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

c. Please explain why you couldn't get tested: _____

For Viewing Only

SECTION C:

READ: Now I have some questions about how coronavirus may be affecting your daily life. I will be asking how it impacts you, your household, your adherence to your medications, and your access to medical care.

29. Has your health care been affected by the pandemic?

- 1- No, I've kept all appointments (Including those moved to telehealth)
- 2- Yes, my doctor office(s) has cancelled or rescheduled one or more of my appointments
- 3- Yes, I have cancelled one or more scheduled doctor appointments or have not gone to the doctor when I felt I needed to

30. Have you had a hard time taking your medications during this pandemic?

(1-Yes, 2-No, 3-Not taking any medications)

If No or Not taking any medications, go to question 31.

If Yes, complete 'a' and continue.

a. Please explain why you had a hard time taking your medications:

31. Were you hospitalized for any other illnesses since January 1, 2020? (1-Yes, 2-No)

If No, go to question 32.

If Yes, continue.

a. For how many days were you hospitalized?

32. In the past two weeks did you feel:

(Please choose 1-Not at all, 2-Very little, 3-Somewhat, or 4-Very Much for each.)

- Calm
- Happy
- Resilient/Strong
- Hopeful
- Optimistic
- Organized
- Sad
- Angry
- Frustrated
- Depressed
- Overwhelmed
- Anxious/Worried
- Scared /Afraid
- Helpless
- Grief
- Hopeless

33. Please rate the level of stress you have felt in the past two weeks about the following issues. Please choose Not at all, Very little, Somewhat, Very Much, or Not applicable for each.

(1-Not at all, 2-Very little, 3-Somewhat, 4-Very much, 5-Not applicable)

- a. Being infected with COVID-19
- b. The possibility of becoming infected with COVID-19
- c. Having a family member(s) or a person you are close with who tested positive for COVID-19
- d. The possibility of a family member or a person close to you becoming infected with COVID-19
- e. Lack of in-person contact with family members and/or friends
- f. Having to restrict family members from in-person social contact
- g. Lack of activities or interactions in the community (church, shopping, gym, etc)
- h. Parenting children who are out of school during this period of sheltering-in-place
- i. Managing the household during this period of sheltering-in-place
- j. Financial challenges due to COVID-19
- k. Difficulties being able to receive needed medications
- l. Difficulties being able to access healthcare due to the system being overloaded with COVID-19
- m. Managing feelings of anxiety, depression, fear, and/or loneliness
- n. Helping your friends navigate through the COVID-19 pandemic
- o. Managing other health conditions during this pandemic

34. Would you like to discuss any other issues you've had with coping during this time? (1-Yes, 2-No)

If Yes, complete 'a' and continue.

If No, go to question 35.

a. Comments:

READ: Thank you for taking the time to answer these questions for us. They will be very helpful to better understand the COVID-19 pandemic and allow us to give continued support to our PHACS participants.

