1. Have you had any of the following in the past two weeks any of the following: (check all that apply)
	* Fever of 100o F or greater
	* Dry Cough
	* Shortness of breath
	* Chills
	* Diarrhea
	* Nausea/Vomiting
	* Sore throat
	* Fatigue
	* Body aches
	* Headache
	* Congestion or runny nose
	* New loss of taste or smell
	* Other symptoms (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* No symptoms
2. Do you have (check all that apply)
* Heart disease
* Lung disease
* Kidney disease
* High blood pressure
* Autoimmune disorders
* Overweight
* Diabetes
1. Have you been diagnosed at any time in having the virus known as COVID-19?
* Yes
* No
1. If “yes” to question 2, were you medically treated for the virus?
* Yes
* No
1. Have you been exposed to anyone close to you who had COVID-19?
* Yes
* No
1. If “yes” to question 4, did you get a COVID-19 test?
* Yes
* No
1. What were the test results?
* COVID-19 positive
* COVID-19 negative
1. If COVID-19 test was positive, did you follow up with medical treatment by a healthcare provider?
* Yes
* No
1. Did you get a COVID-19 Vaccine?
* Yes
* No
1. If you did get a COVID-19 Vaccine, which one?
* Pfizer-BioNTech
* Moderna
* Johnson & Johnson
1. If you did get a COVID-19 Vaccine, did you have ill (ie; unable to do normal activities) side effects?
* Yes
* No

The following questions pertain to the time period before the vaccine and/or lifting of restrictions.

1. Do you go out in public?
* Yes
* No
1. If “yes” to question 12, how often do you go out in public? (choose one)
* Once a week
* Two to three times a week
* Every day
1. When out in public, how do you avoid COVID-19? (check all that apply)
* Wear face mask
* Wear gloves
* Wear glasses (for protection)
* Keep 6 feet distance from others when possible
* Use hand sanitizer regularly and/or wash hands regularly when out in public
* Avoid any size public gathering of people
* Avoid touching objects in public (e.g., elevator buttons, or doorknobs)
* I don’t wear any protective equipment or do anything special
1. When at home, how do you avoid COVID-19 (check all that apply)
* Clean frequently surface areas at home
* Don’t have guests over
* Have groceries delivered
* Wipe down any delivered groceries with sanitizer
* Order restaurant food and have it delivered
* Maintenance service people who must enter home have to be masked
* I don’t do anything special
1. Feeling nervous, anxious or on edge
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. Not being able to stop or control worrying
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. Worrying too much about different things
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. Trouble relaxing
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. Being so restless that it is so hard to sit still
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. Becoming easily annoyed or irritable
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. Feeling afraid, as if something awful might happen
* 0 Not at all
* 1 Several days
* 2 More than half the days
* 3 Nearly every day
1. I’ve been feeling optimistic about the future
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling useful
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling relaxed
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling interested in other people
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve had energy to spare
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been dealing with problems well
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been thinking clearly
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been thinking good about myself
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling close to other people
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling confident
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been able to make up my own mind about things
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling loved
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been interested in new things
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. I’ve been feeling cheerful
* 1 None of the time
* 2 Rarely
* 3 Some of the time
* 4 Often
* 5 All of the time
1. Has the COVID-19 pandemic affected your ability to receive care for known chronic diseases?
* Yes
* No
1. Please specify how your ability to receive care at facilities other than the RE Mitchell Center for POW Studies for your chronic disease has been affected by the COVID-19 pandemic (Check all that apply):
* No Impact
* Delayed appointments
* Cancelled appointments
* Delayed Laboratory testing
* Cancelled Laboratory testing
* Delayed Imaging (x-rays, CT, ultrasound, etc)
* Cancelled Imaging (xrays, CT, ultrasound, etc)
* Delayed treatments (medications, radiation, surgery, etc)
* Cancelled treatments (medications, radiation, surgery, etc)
1. Has the COVID-19 pandemic affected your access to or use of preventive health services or screenings?
* Yes
* No

Please provide any necessary additional or clarifying comments: