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: