SPIROMICS
SubPopulations and InteRmediate Outcome Measures In COPD Study

COVID-19 QUESTIONNAIRE

ID NUMBER:										FORM CODE: VID VERSION: 1.0 04/04/2025	Event: _____

0a) Date of Collection ☐☐ / ☐☐ / ☐☐☐☐ 0b) Staff Code ☐☐☐

Instructions: This form should be completed during the participant's in-person clinic visit.

In this questionnaire, we will be asking about your COVID-19 infection and vaccination history. A number of questions are about events that could have occurred two or more years ago and may be difficult to recall in detail. In these cases, please answer to the best of your ability, and provide 'best estimates' if you can.

1) Have you ever been infected with COVID-19?
   - ☐ No$_0$ → **Go to 12**
   - ☐ Yes$_1$

2) In total, since the beginning of the COVID-19 pandemic in the US (March 2020), how many times do you **think** you have been infected with COVID-19? (please estimate even if you are not sure)
   - ☐ 1 infection (only once)$_1$ → **Go to 3**
   - ☐ 2 infections (reinfected once)$_2$ → **Go to 3**
   - ☐ 3 infections (reinfected twice)$_3$ → **Go to 3**
   - ☐ More than 3 infections$_4$
   - ☐ Do not know$_5$ → **Go to 3**

   2a) If more than 3 COVID infections, please list the number: ☐☐

3) Have you ever been hospitalized for COVID-19?
   - ☐ No$_0$ → **Go to 5**
   - ☐ Yes$_1$

4) How many times have you been **hospitalized for COVID-19**?
   - ☐ 1 COVID hospitalization$_1$ → **Go to 5**
   - ☐ 2 COVID hospitalizations$_2$ → **Go to 5**
   - ☐ 3 COVID hospitalizations$_3$ → **Go to 5**
   - ☐ More than 3 COVID hospitalizations$_4$
   - ☐ Do not know$_5$ → **Go to 5**

   4a) If more than 3 COVID hospitalizations, please list the number: ☐☐

The following five questions refer to your <u>most recent</u> COVID-19 infection.

5) When do you know or think you last had COVID-19? (please estimate even if you are not sure)

☐☐/☐☐☐☐

6) Did you take a COVID test at that time?

☐ No$_0$→ **Go to 8**

☐ Yes$_1$

7) Did you have a positive test result? "Positive" means the test showed COVID-19.

☐ No$_0$

☐ Yes$_1$

☐ Do not know$_2$

8) Did you have any COVID-19 symptoms, such as fever, cough, sore throat, or other symptoms?

☐ No$_0$→ **Go to 10**

☐ Yes$_1$

9) When your COVID-19 symptoms were at their worst, did they prevent you from going about your daily activities?

☐ Not at all$_0$

☐ A little bit$_1$

☐ Somewhat$_2$

☐ Quite a bit$_3$

☐ Very much$_4$

Recovery from COVID-19

13 10) Would you say that you are completely recovered from COVID-19 now?

☐ No$_0$→ **Go to 12**

☐ Yes$_1$

14 11) How long did it take for you to recover from your most recent infection? (please estimate even if you are not sure):

☐ 2 weeks or less$_1$

☐ 3-6 weeks$_2$

☐ 7-12 weeks$_3$

☐ 3-6 months$_4$

☐ More than 6 months$_5$

Vaccination against COVID-19

15 12) Have you ever been vaccinated against COVID-19?

☐ No$_0$→ **END FORM**

☐ Yes$_1$

☐ Do not know$_2$→ **END FORM**

16 13) In total, how many COVID-19 vaccine shots have you received?

- ☐ 1 1 → **END FORM**
- ☐ 2 2 → **END FORM**
- ☐ 3 3 → **END FORM**
- ☐ 4 4 → **END FORM**
- ☐ 5 5 → **END FORM**
- ☐ More than 5 6
- ☐ Do not know 7 → **END FORM**

13a) If more than 5, please specify how many: ☐

END OF FORM