CaG COVID-19 FOLLOW-UP QUESTIONNAIRE
Version 2021-02-01 English

As the current COVID-19 pandemic continues to affect our lives, we are seeking your help to better understand and track the disease.

This questionnaire is designed to assess the impact that COVID-19 may have had on your physical and mental health. If you have already answered the previous questionnaire, some of your previous answers will already be filled in and you will only have to modify them if there is a change. We wish to collect information about the known risk factors for COVID-19, and to learn about how the pandemic affected other parts of your life, such as your social support network and employment status.

Even if you have not experienced COVID-19 symptoms, please take time to fill out the questionnaire - your answers are still valuable to health research.

The questionnaire is automatically saved when you go to the next section. This way, you can complete a portion of this survey and come back later to complete it. Please follow the instructions carefully.

Thank you for completing this questionnaire as soon as possible or within a maximum of 7 days.

Note to the researchers: participants providing multiple blood spot samples will be asked to respond to the questions highlighted in yellow on the 2nd and 3rd blood sample.

1. COVID-19 DIAGNOSES

DG03. As of today, have you been tested for COVID-19?

1 Yes
2 No – because I haven't experienced any symptoms
3 No – I have experienced one or more symptoms (for example, a cough, mild fever, muscle soreness, fatigue) but have not been tested
4 No – I have experienced symptoms but I do/did not meet the testing criteria
8 Prefer not to answer

DG03N [IF DG03=1] How many times were you tested?

1
2
3
4 ajouter jusqu'à 8 (4 premiers prérempli)

DG03_Ter. [Repeat DG03_Ter-DG05-DG06bis-DG04 as needed] For your first test, what was the type of test?

Viral test (a nasal or throat swab for current infection)
Antibody/serology test (blood test for past infection)

DG05. [Repeat DG03_Ter-DG05-DG06bis-DG04 as needed (1-8 times)] What was the date of your 1st/2nd/3rd/4th... 8th COVID-19 test?

If you don't remember the exact date, please provide the best estimate that you can. Alternatively, you can indicate the first day of the month you were being tested or leave it empty.

Value (DD-MM-YYYY)

DG06bis. How long did it take to obtain the result of your 1st/2nd/3rd/4th...8th COVID-19 test?

Value (Number of days)

DG04. What was the result of your 1st/2nd/3rd/4th... 8th COVID-19 test?

0 Negative
1 Positive
8 Prefer not to answer
9 Don't know or have not received results yet

DG07. [IF DG03=3,4] Do you suspect you have/had an undiagnosed case of COVID-19?

1 Yes
0 No
9 Don't know

DG02. Why do you think you have, or have had, COVID-19?
[SELECT ALL THAT APPLY]

1 Took a self-assessment online
2 Had symptoms that could be COVID-related (e.g., fever, sore throat, runny nose, difficulty breathing, etc.) that cannot be attributed to a previously existing condition
4 Told by a health care provider
5 Had contact with someone who tested positive for COVID-19
6 Other : _____

DG02_Bis. [if yes to Contact with someone who tested positive for COVID-19] On which date did you have first contact with this person after they were diagnosed with COVID-19? If you don't remember exactly when, please choose an approximate date.
DD/MM/YYYY (date calendar – participant chooses date)
Don't know

DG02_Ter. [if yes to Contact with someone who tested positive for COVID-19] Who was this person with COVID-19?
Spouse or partner
Family member living in the same place
Family member living in another place
Housemate
Friend
Work colleague
Other : _____

2. COVID-19 SYMPTOMS

*We are interested in whether you have experienced flu-like and other symptoms, which may be related to COVID-19. For these next questions, please consider any symptoms which **are not due to other health issues** you might usually experience/expect, such as perennial or seasonal allergies, existing medical conditions, etc.*

SY01. Have you had a fever since January 1st, 2020 (>38 °C)?
1 Yes
0 No
9 Don't know

SY02. [IF SY01=1] How long did it last?
Please indicate the number of days with fever. If you had more than one fever, answer this question for the longest fever.
If you don't remember the exact duration, please provide the best estimate that you can or leave it empty.
Number of days:

SY04. Since January1, 2020, have you experienced any of the following symptoms?
It is important to report any of the symptoms below that you could have experienced in an unusual or abnormal way, that have been more severe or more sudden than usual.
Please do not include symptoms related to factors you might usually experience/expect, such as perennial or seasonal allergies, usual migraine or existing medical conditions (e.g., asthma). One answer per line is needed.

	0 No	1 Mild	2 Moderate	3 Severe
Dry cough				
Wet cough (cough that produces mucus)				
Runny nose				
Sinus pain				

	0 No	1 Mild	2 Moderate	3 Severe
Ear pain				
Sore throat				
Hoarseness				
Shortness of breath or difficulty breathing				
Headache				
Fatigue				
General muscle and/or joint aches and pains				
Chills or shivering				
Loss of taste				
Loss of sense of smell				
Diarrhea				
Loss of appetite				
Nausea				
Vomiting				
Wheezing				
Chest pain				
Confusion				
Dizziness				
Abdominal pain				
Other – Please specify:				

SY04_Bis. [IF YES TO ANY SYMPTOMS] When did you first experience these symptoms?

If you don't remember the exact date, please provide the best estimate that you can or leave it empty.

Date: (DD-MM-YYYY)

SY04_Ter. [IF YES TO ANY SYMPTOMS] When did you experience the most recent symptoms?
If you don't remember the exact date, please provide the best estimate that you can or leave it empty.
Value (DD-MM-YYYY)

SY05. IF YES TO ANY SYMPTOMS] Do you continue to experience COVID-19 symptoms?
1 Yes
0 No
9 Don't know

SY06. [IF SY05=0] How long were you sick for?

If you don't remember the exact duration, please provide the best estimate that you can or leave it empty.

Number of days:

SY07_Bis. [IF YES to SY01 or SY04] When the first symptoms appeared, what did you do?

Called the 811
Called a dedicated coronavirus *hotline (1-888-COVID19 or 1-877-644-4545)*
Called or consulted your family doctor
Went to a COVID-19 screening clinic
Went to the Hospital emergency room
Went to the pharmacy
Nothing
Other : Please specify
Don't know

SY07_Ter. [IF YES to SY01 or SY04] Did you manage to reach or see someone?

Yes, I have seen a doctor.
Yes, I had a screening test.
Yes, I managed to reach someone after my first call.
Yes, I managed to reach someone after several calls.
Yes, I hung up because there was too much waiting but I was called back.
No, there was too much waiting and I was not called back.
No, there was too much waiting and I did not have a screening test.

SY08. [IF YES to SY01 or SY04] While you were experiencing COVID-19 related symptoms, did you have close contact with any of the following people?

Close contact means physical contact such as hugging, kissing, shaking hands, etc.

	Yes	**No**	**Don't know / Not applicable**
Spouse or partner			
Family members living in the same place			
Family members living in another place			
Roommates			

Friends			
Work colleagues			

SY09. [IF SY08=YES] Has any of these people developed COVID-related symptoms?

	Yes	No	Don't know / Not applicable
Spouse or partner			
Family members living in the same place			
Family members living in another place			
Roommates			
Friends			
Work colleagues			

SY09_Bis [IF SY09=YES] For the people that developed COVID-related symptoms, which category/categories did they belong to and how many individuals were affected?

Select all that apply.

	None	1	2	3	4	5	6	7	8	9	10 and more	Don't know / Not applicable
Spouse or partner												
Family members living in the same place												
Family members living in another place												
Roommates												
Friends												
Work colleagues												

3. COVID-19 - CARE/HOSPITAL RELATED INFORMATION

CH01. Were you hospitalized because of COVID-19?

1 Yes
0 No
9 Don't know

CH01_Bis. During the COVID-19 pandemia, were you hospitalized for a different reason but infected by COVID-19 during your hospitalization?

1 Yes

0 No
9 Don't know

CH02. [IF CH01 OR CH01_Bis=YES] What date did you get admitted to the hospital?
If you don't remember the exact date, please provide the best estimate that you can. Alternatively, you can indicate the first day of the month you were hospitalized or leave it empty.

Date : DD-MM-YYYY

CH03. [IF CH01 OR CH01_Bis=YES] How many days were you in the hospital?
If you don't remember the exact duration, please provide the best estimate that you can or leave it empty.

Number of days

CH04. [IF CH01 OR CH01_Bis=YES]Were you admitted to an intensive care unit?
1 Yes
0 No
9 Don't know

CH05. [IF CH04=YES] How long did you stay in the intensive care unit?
If you don't remember the exact duration, please provide the best estimate that you can or leave it empty.

Number of days

CH10. [IF CH01 OR CH01_Bis=YES] Did you continue to experience COVID-19 symptoms or complications related to hospitalization after you were discharged?
1 Yes
0 No
9 Don't know

DG08. Did you receive treatment with any experimental therapies for COVID-19 for prevention or treatment?
0 Yes
1 No
8 Prefer not to answer
9 Don't know

DG09. [IF DG08=YES] Which experimental therapy did you receive?
Select all that apply.

1 Remdesivir
2 Chloroquine/Hydroxychloroquine
3 Lopinavir-Ritonavir
4 Tocilizumab
5 Colchicine
6 Other Please specify:
8 Prefer not to answer
9 Don't know

DG10 [IF DG08=YES]. Were the therapy prescribed to you by a clinician for COVID-19?
1 Yes
0 No
8 Prefer not to answer
7 Don't know

4. COVID-19 – EXPOSURE

EX01. Did you travel outside your home province after January 1st, 2020?
This includes tourism and business trips, within the province of Québec as well as outside (Canada and international).
1 Yes
0 No
9 Don't know / Prefer not to answer

EX02. [IF EX01=YES] Where did you travel?
Select all that apply below.

1. Domestic, outside the province of Québec but within Canada
   If yes, what province did you travel to? Select all that apply.

Alberta
British Columbia
Manitoba
New Brunswick
Newfoundland & Labrador
Northwest Territories
Nova Scotia
Nunavut
Ontario
Prince Edward Island
Quebec
Saskatchewan
Yukon

When and how many times did you travel here since January 1st, 2020?

Location	How many times did you travel here since Jan 1, 2020	Which months did you travel? (list of months and years)
Alberta	(e.g. 3)	
BC		
…		

2. International

If yes, what countries did you travel to

Australia
Caribbean countries
China
France
Germany
India
Iran
Italy
Mexico
New Zealand
Thailand
United Kingdom
United States of America
Other(s) – specify (please separate by commas – e.g., Brazil, Malaysia, etc.)

When and how many times did you travel here since January 1st, 2020?

Location	How many times did you travel here since Jan 1, 2020	Which months did you travel? (list of months and years)
Alberta	(e.g. 3)	
BC		
…		

EX03. We're interested in whether other people may have exposed you to COVID-19. To your knowledge, have you been in the same room as a person who was diagnosed with COVID-19 by a physician or who has been positively tested with COVID-19?

1 Yes
0 No
9 Don't Know

EX04. How many times have you been in a gathering of more than 10 people since March 2020? Please consider the number of gatherings that occurred indoors and outdoors.
Number of indoor gatherings:
Number of outdoor gatherings:

EX04_Bis [IF ANSWERED 1+ TO INDOOR]. Was it by respecting public health recommendations (i.e., wearing mask, social distancing, etc.) (indoor gatherings)?
1 Always
2 Most of the time
3 Sometimes/Rarely
4 Never

EX04_Ter [IF ANSWERED 1+ TO OUTDOOR]. Was it by respecting public health recommendations (i.e., wearing mask, social distancing, etc.) (outdoor gatherings)?
1 Always
2 Most of the time
3 Sometimes/Rarely
4 Never

EX05. To your knowledge, since January 1st, 2020, have you been in the same room as someone who went on to develop symptoms of COVID-19?
COVID-19 symptoms include, among others, fever, severe fatigue, shortness of breath, dry cough, muscle pain or increased phlegm production.
1 Yes
0 No
9 Don't Know

EX06. [IF YES] On which date were you in the same room with this person before the onset of COVID-19 symptoms?
If you don't remember the exact dates of contact, please provide the best estimate that you can or leave it empty.
DD MM YYYY

EX06_Ter [IF EX06=YES] Who was this person with COVID-19 symptoms?
Spouse or partner
Family member living in the same place
Family member living in another place
Roommate
Friend

Colleague
Other : please specify

EX07. To your knowledge, have you been in the same room as a person who returned from an international trip after January 1st, 2020?

If you have travelled internationally since January 1st, 2020, do not include people that you travelled with.

1 Yes
0 No
9 Don't Know

EX08. [IF EX08=YES] On which date were you in the same room with this person?

If you don't remember the exact dates of contact, please provide the best estimate that you can or leave it empty.

DD MM YYYY

For the next questions, please use the following definitions:
***Self-isolation**: no symptoms or positive test, but stayed at home other than essential errands or exercise, including working from home when possible.*
***Quarantine:** did not leave your house or yard due to recent travel, symptoms, positive test, or possible exposure to someone diagnosed with COVID-19.*

EX10. Since March 2020, how often have you done the following?

	Never	Rarely	Occasionally	Often	Always
Wore a mask in public places indoors or where physical distancing was not possible					
Practiced physical distancing in public places					
Avoided crowded places/gatherings					
Avoided common greetings (e.g., shaking hands, hugging)					
Limited contact					

	Never	Rarely	Occasionally	Often	Always
with people at higher risk (e.g., an elderly relative)					
Interacted with a 'cohort family' (another family or small group of close friends who socialize/interact only with each other)					
Taken public transit					
Practiced public health guidelines for handwashing (e.g., wash hands with soap and water for at least 20 seconds)					
Carried hand sanitizer or disinfecting wipes with you when you are outside the house					
Avoided leaving the house for non-essential reasons					
Self-quarantined because you may have been exposed to COVID-19, but did not show symptoms					
Self-quarantined because you thought you were infected with COVID-19					
Worked from					

	Never	Rarely	Occasionally	Often	Always
home					
Stocked up on essentials at a grocery store or pharmacy					
Wore gloves when going out in public					

Other: Please specify

EX12_Bis. If you changed your transportation habits, what was (were) the reason(s)?
Select all that apply.

I did not change my transportation habits
I was afraid of catching COVID-19 on public transit
I no longer needed to commute because of the confinement
I was in quarantine or in self-isolation
I had symptoms of COVID-19
I prefer not to answer
Other: Please specify

EX13. To date, have you self-isolated during the COVID-19 pandemic?

1 Yes
0 No
8 Prefer not to answer

EX14. [IF EX13=YES] How long were you in self-isolation?
If you don't remember the exact duration, please provide the best estimate that you can or leave it empty.

Number of days:
OR
Number of weeks:

EX17. To date, have you been in quarantine during the COVID-19 pandemic?

1 Yes
0 No

8 Prefer not to answer

EX18. [IF EX17=YES] How long were you in quarantine?

If you don't remember the exact duration, please provide the best estimate that you can or leave it empty.

Number of days:
OR
Number of weeks:

EX21. Are you working as a medical professional?

This includes physician, nurse, hospital or CHSLD employee, first responder or pharmacist in direct contact with patients.

1 Yes
0 No
8 Prefer not to answer
9 Don't know

EX22. Are you working as an essential service provider (grocery store, public transit, police, security, etc.) with regular contact with the public?

1 Yes
0 No
8 Prefer not to answer
9 Don't know

D14. After March 13th (date of shutdown), if you are still working, were some arrangements made in your workplace?

Select all that apply.

Information on social distancing and hygiene precautions (i.e., posters on how wash hands efficiently)
Implementation of physical distancing measures
Installation of a physical barrier (e.g., cubicle, plexiglass, plastic shields, etc.)
Masks provided
Disinfectant solution or hydroalcoholic gel provided
Protective gloves provided
Regular disinfection of material and space (e.g., keyboards and work surfaces)

D15. Do you consider that these arrangements and the health and safety conditions protect you from the virus in a way that is:

Completely sufficient
Rather sufficient
Not really sufficient
Not at all sufficient

Don’t know

3. DEMOGRAPHIC INFORMATION

For the following questions, please modify the answers if there are any changes if you answered the previous questionnaire.

DE07. How many adults (age 18 or older) and children (under 18 years of age) including yourself are currently living in your household?

Number of children under 18 years old: ___
Number of adults 18 to 59 years old: ___
Number of adults 60 to 69 years old: ___
Number of adults 70 to 79 years old: ___
Number of adults 80 years old or more: ___

DE08. What type of dwelling do you currently live in?

0 House (e.g., single detached, semi-detached, duplex or townhouse)
1 Apartment or condominium
2 Seniors’ housing (e.g., retirement home, senior lodges, senior residences, assisted living)
3 Institution (e.g., long-term care facility, nursing home)
4 Other (e.g. mobile home, hotel, rooming house, or group home)
5 Don’t know
6 Prefer not to answer

A8. How many individual bedrooms does your dwelling have?

Number of room:

A9. How many bathrooms does your dwelling have?

Number of bathroom:

A12. Do you have a pet in your home?

Yes
No

A13. [IF A12=YES] What kind of pet and how many?

How many dogs:
How many cats:
How many birds:
Other: Please specify:
How many:

A5. In which region do you currently live?

Abitibi-Témiscamingue
Bas-Saint-Laurent
Capitale-Nationale
Chaudière-Appalaches
Côte-Nord
Estrie
Gaspésie et les Îles-de-la-Madeleine
Laval
Lanaudière
Laurentides
Mauricie et le Centre-du-Québec
Montérégie
Montréal
Nord-du-Québec
Nunavik
Outaouais
Saguenay-Lac-Saint-Jean
Terres-Cries-de-la-Baie-James
I live in Canada but outside Quebec
I do not live in Canada

A6. What is your current postal code?

Your postal code will used to define the characteristics of the environment where you currently live. With regard to COVID-19, it will help to understand the geographic spread of the pandemia as well as the health care and diagnosis services distribution.
If you do not wish to provide a 6-digit postal code, you may provide the first 3 digits.
Postal code:
I live outside Canada

A7. In what country were you born?

Canada
Other country: _____
I prefer not to answer
I don't know

4. RISK FACTORS

MC06. What is your blood type?

1 A
2 B
3 AB
4 O

9 Don’t know

E5. Compared to before the pandemic, have you changed your level of physical activity during the COVID-19 pandemic?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E6. Compared to before the pandemic, has your sleep duration changed during the COVID-19 pandemic?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E6_Bis. Compared to before the pandemic, has the quality of your sleep changed during the COVID-19 pandemic?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E7. Compared to before the pandemic, has the quality of your food changed during the COVID-19 pandemic?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E7_Bis. Compared to before the pandemic, has your food intake changed during the COVID-19 pandemic?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

As COVID-19 virus affects the respiratory system, the next few questions ask about smoking cigarettes, e-cigarettes and cannabis.

RF01. At the present time, do you smoke cigarettes daily, occasionally, or not at all?

1 Daily (At least one cigarette every day for the past 30 days)
2 Occasionally (At least one cigarette in the past 30 days, but not every day)
3 Not at all (You did not smoke at all in the past 30 days)

RF04. At the present time, are you using electronic cigarettes, also known as e-cigarettes? Vaping products have many names, such as: e-cigarettes, vape pens, vapes, mods, tanks, and e-hookahs. They may also be known by various brand names.

1 Daily (At least one e-cigarette every day for the past 30 days)
2 Occasionally (At least one e-cigarette in the past 30 days, but not every day)
3 Not at all (You did not use e-cigarettes at all in the past 30 days)
4 I have never used e-cigarettes
8 Prefer not to answer

RF06. At the present time, are you using cannabis?

1 Daily (At least one cigarette every day for the past 30 days)
2 Occasionally (At least one cigarette in the past 30 days, but not every day)
3 Not at all (You did not use cigarettes at all in the past 30 days)
4 I have never used cannabis
8 Prefer not to answer

RF08. Which of the following methods to consume cannabis did you most often use?

1 Smoked
2 Vaporized
3 Consumed in food or drink
4 Other: Please specify
8 Prefer not to answer
9 Don't know

RF10. At the present time, how often do you drink alcohol?

1 Less than once a month
2 About once a month
3 2 to 3 times a month
4 Once a week

5 2 to 3 times a week
6 4 to 5 times a week
7 6 to 7 times a week
0 Never
9 Don't know

5. MEDICAL CONDITIONS

If you answered the previous questionnaire, this section will repeat your answers. In case of new medical conditions diagnosed since the previous questionnaire, please modify the corresponding answers.

COVID-19 is a new disease and knowledge of risk factors is evolving. People who have pre-existing medical conditions, or who have compromised immune systems, may be at higher risk of serious illness. For this reason, we would like to know more about your pre-existing medical conditions.

MC01. Has a doctor ever told you that you had a cancer or a malignancy of any kind?
1 Yes
0 No
9 Don't know

MC02. [IF MC01=YES] What type of cancer was it?

Type of Cancer	Are you currently undergoing treatment?	[IF SELECTED] What kind of treatment is it?
Bladder	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Breast	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know

Type of Cancer	Are you currently undergoing treatment?	[IF SELECTED] What kind of treatment is it?
Cervix	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Colon	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Esophagus	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Kidney	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Larynx	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Leukemia	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy

Type of Cancer	Are you currently undergoing treatment?	[IF SELECTED] What kind of treatment is it?
		Other specify Don't know
Liver	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Lung and bronchus	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Lymphoma (Hodgkin Lymphoma)	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Lymphoma (non-Hodgkin Lymphoma)	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Mouth, tongue or throat	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Multiple myeloma	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery

Type of Cancer	Are you currently undergoing treatment?	[IF SELECTED] What kind of treatment is it?
		Laser therapy Cell therapy Other specify Don't know
Ovary	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Pancreatic	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Prostate	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Rectum	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Skin (Melanoma)	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Skin (Non-Melanoma)	1 Yes	Chemotherapy

Type of Cancer	Are you currently undergoing treatment?	[IF SELECTED] What kind of treatment is it?
	0 No 9 Don't know	Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Small intestine	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Stomach	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Testicle	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Thyroid	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know
Uterus	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify

Type of Cancer	Are you currently undergoing treatment?	[IF SELECTED] What kind of treatment is it?
		Don't know
Other: _____	1 Yes 0 No 9 Don't know	Chemotherapy Radiation Surgery Laser therapy Cell therapy Other specify Don't know

MC03. Has a doctor ever told you that you had…?

Condition	**Diagnosed**	[IF SELECTED] **Are you currently being treated?**
Diabetes	1 Yes 0 No 9 Don't know If yes, which type of diabetes was it? Type 1 diabetes Type 2 diabetes	 1 Yes 0 No 9 Don't know
Heart and circulatory conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	High blood pressure (hypertension, not including during pregnancy)	1 Yes 0 No 9 Don't know
	Heart attack (myocardial infarction)	1 Yes 0 No 9 Don't know
	Heart failure	1 Yes 0 No 9 Don't know
	Atherosclerosis / Coronary heart disease (including angioplasty or stents)	1 Yes 0 No 9 Don't know
	Atrial fibrillation	1 Yes

Condition	**Diagnosed**	[IF SELECTED] **Are you currently being treated?**
		0 No 9 Don't know
	Angina	1 Yes 0 No 9 Don't know
	Heart murmur	1 Yes 0 No 9 Don't know
	Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)	1 Yes 0 No 9 Don't know
Respiratory system conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Asthma	1 Yes 0 No 9 Don't know
	Chronic obstructive pulmonary disease (COPD)	1 Yes 0 No 9 Don't know
	Interstitial lung disease	1 Yes 0 No 9 Don't know
	Chronic bronchitis	1 Yes 0 No 9 Don't know
	Cystic fibrosis	1 Yes 0 No 9 Don't know
	Emphysema	1 Yes 0 No 9 Don't know
	Sleep apnea	1 Yes 0 No 9 Don't know
Gastrointestinal conditions	1 Yes 0 No 9 Don't know	

Condition	**Diagnosed**	[IF SELECTED] **Are you currently being treated?**
	If yes, select all that apply:	
	Crohn's disease	1 Yes 0 No 9 Don't know
	Ulcerative colitis	1 Yes 0 No 9 Don't know
	Irritable bowel syndrome	1 Yes 0 No 9 Don't know
	Celiac disease	1 Yes 0 No 9 Don't know
	Stomach ulcers	1 Yes 0 No 9 Don't know
	Persistent acid reflux/Gastroesophageal reflux disease (GERD)	1 Yes 0 No 9 Don't know
Liver or pancreas conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Liver cirrhosis	1 Yes 0 No 9 Don't know
	Chronic hepatitis	1 Yes 0 No 9 Don't know
	Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)	1 Yes 0 No 9 Don't know
	Gallstones	1 Yes 0 No 9 Don't know
Renal disease / kidney failure conditions	1 Yes 0 No 9 Don't know	

Condition	**Diagnosed**	[IF SELECTED] **Are you currently being treated?**
	If yes, select all that apply:	
	Acute renal failure	1 Yes 0 No 9 Don't know
	Chronic renal failure	1 Yes 0 No 9 Don't know
	Kidney stones	1 Yes 0 No 9 Don't know
Mental health condition	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Major depression	1 Yes 0 No 9 Don't know
	Minor depression	1 Yes 0 No 9 Don't know
	Bipolar disorder	1 Yes 0 No 9 Don't know
	Post-traumatic stress disorder	1 Yes 0 No 9 Don't know
	Schizophrenia or Schizoaffective disorder	1 Yes 0 No 9 Don't know
	Obsessive compulsive disorder	1 Yes 0 No 9 Don't know
	Anxiety disorder	1 Yes 0 No 9 Don't know
	Eating disorder	1 Yes 0 No 9 Don't know
	Addiction disorder (e.g. alcohol, drug or gambling	1 Yes 0 No

Condition	Diagnosed	[IF SELECTED] **Are you currently being treated?**
	dependence)	9 Don't know
Neurological conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Thrombotic stroke	1 Yes 0 No 9 Don't know
	Hemorrhagic stroke	1 Yes 0 No 9 Don't know
	Multiple sclerosis	1 Yes 0 No 9 Don't know
	Migraines	1 Yes 0 No 9 Don't know
Arthritis	1 Yes 0 No 9 Don't know Which type(s) of arthritis was it? Rheumatoid arthritis Osteoarthritis Don't know Other (please specify): _____	1 Yes 0 No 9 Don't know
Bone and joint conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Lupus	1 Yes 0 No 9 Don't know
	Fibromyalgia	1 Yes 0 No 9 Don't know
	Osteoporosis	1 Yes

Condition	Diagnosed	[IF SELECTED] **Are you currently being treated?**
		0 No 9 Don't know
Skin conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	Eczema	1 Yes 0 No 9 Don't know
	Rosacea	1 Yes 0 No 9 Don't know
	Psoriasis	1 Yes 0 No 9 Don't know
	Scleroderma	1 Yes 0 No 9 Don't know
Immune system conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:	
	HIV	1 Yes 0 No 9 Don't know
	A weakened or compromised immune system such as Severe Combined Immunodeficiency	1 Yes 0 No 9 Don't know
	Hashimoto's thyroiditis, Sjögren's syndrome, or Ankylosing spondylitis	1 Yes 0 No 9 Don't know
Other (up to 3 'other' conditions can be entered)	1 Yes 0 No 9 Don't know Text box	1 Yes 0 No 9 Don't know

MC04. Have you ever received an organ, bone marrow, or stem cell transplant?

1 Yes
0 No
9 Don't know

MC05. [IF MC04=YES] Are you currently taking immunosuppressive medication?

1 Currently taking each day
2 Taken within the last few months (during the COVID-19 pandemic) but not every day
3 Taken before Jan 2020 but not currently
4 No, I am not taking immunosuppressive medication
9 Don't know

MC07. Since March 2020, access to health services may have changed. Have you experienced any of the following changes related to your healthcare?

Select all that apply.

Surgery cancelled or deferred
Medical procedure (e.g. diagnostic or screening) cancelled or deferred
Treatment cancelled or deferred
Other health-related appointment cancelled or deferred (e.g. dental, vision, etc.)
Use of virtual appointments with health care provider
Delayed seeing a healthcare professional about an existing problem or concern
Delayed seeing a healthcare professional about a new problem or concern
Delayed routine healthcare service or visit (e.g. procedure, treatment or lab test)
Regular lab tests cancelled or deferred
Medication shortage
Other (text box)
None or not applicable

MC08 [if any of the Delayed options are selected] If you delayed pursuing a health service or treatment, what were the reasons (select all that apply):

I was not comfortable seeking health services
Regular health service provider was not accepting appointments
I wanted to ensure the health system was available to others who may need it
I lost my health benefits (e.g. my hours were reduced and/or I was laid off)
I could not afford to access the services
Other – please specify:

F1. Do you have a family physician/primary care provider?

0 No
1 Yes
9 Don't Know

F2. Are you involved in any other COVID-related studies? Select all that apply.

Yes – a vaccine trial
Yes – experimental treatment(s) (e.g., remdesivir, hydroxychloroquine, etc.)

Yes – serology/antibody testing (excluding this study)
Yes - other
No
Prefer not to answer

F3. Did you receive a seasonal influenza vaccination in 2019/2020?

No
Yes
Don't know / Prefer not to answer

F3_Bis. Did you receive a seasonal influenza vaccination in 2020/2021?

No
Yes
Don't know / Prefer not to answer

F4. Did you ever receive a BCG vaccination?

No
Yes
Don't know / Prefer not to answer

When this questionnaire was developed, there was a great deal of enthusiasm for potential vaccines from multiple manufacturers.

OT04. Is a vaccine to COVID-19 available to you now?
Yes
No (skip to OT09)

OT05 [IF YES to OT04] Have you received a vaccine against COVID-19?
Answer 'Yes' if you have received at least one dose of the COVID-19 vaccine.
Note: Certain types of vaccines require more than one dose to protect against COVID-19.
Yes
No (skip to OT09)

OT05_Bis [IF YES to OT05] Have you received this vaccine as part of a vaccine trial?
Yes
No

OT06. Which vaccine did you receive?
Pfizer and BioNTech mRNA vaccine
Moderna mRNA vaccine
AstraZeneca Oxford vaccine
Other:
Don't know

OT07. How many doses did you receive?
Note: Certain types of vaccines require more than one dose to protect against COVID-19. You would have been informed at the time of vaccination if you needed a second dose.
One dose
Two doses
Three doses

OT08. [Repeat as many times as is indicated in OT07.] When did you receive the 1st/2nd/3rd COVID-19 vaccine(s)? (YYYYMMDD)

Repeat OT08 as many times as is indicated in OT07.

OT09 [do not show if OT05=Yes] Would you be willing to take a vaccine against COVID-19?
Yes
No
Don't know

OT10. Have you received a blood transfusion in the past 2 months?
0 No
1 Yes

OT11. Have you received chemotherapy in the past 3 months?
0 No
1 Yes

OT12. Have you received radiotherapy treatment in the last 3 months?
0 No
1 Yes

6. MEDICATION

If you answered the previous questionnaire, this section will repeat your answers. If necessary, please modify the answers if there has been a change in your medication intake.

ME01. Are you currently taking or have taken in the past 12 months any of the medication listed below (select all that apply):

If the medication does not appear in one class, it may be present in another class. Please take time to go through the different categories.

Medication Type	Have you taken these in the past 12 months?
Medication to lower blood pressure from the ACE-inhibitors class (angiotensin-converting inhibitor).	1 Yes 0 No 9 Don't know

Medication Type	Have you taken these in the past 12 months?
This includes benazepril, captopril, enalapril, lisinopril, Ramipril, etc.	[IF YES] Which one? Name of drug (list) DIN :
Medication to lower blood pressure from the angiotension II Receptor Blockers. This includes candesartan, losartan, telmisartan, valsartan, etc.	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Antibiotics	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Antivirals (e.g. lopinavir-ritonavir, remdesivir)	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Allergy medications	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Androgen deprivation therapy	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Asthma medications	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Immunosuppressive or immunomodulatory medication (e.g. corticosteroids; disease-	1 Yes 0 No

Medication Type	Have you taken these in the past 12 months?
modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)	9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Blood thinners (e.g. apixaban, rivaroxaban, dabigatran)	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Non-steroidal anti-inflammatory drugs (e.g. ibuprofen such as Advil or Motrin; naproxen such as Aleve)	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :
Other pain/fever relievers (e.g. aspirin, paracetamol or acetaminophen)	1 Yes 0 No 9 Don't know [IF YES] Which one? Name of drug (list) DIN :

ME02. Are you currently taking or have you taken vitamin D supplements in the past 12 months?

1 Yes, currently taking every day
2 Yes, taken regularly but not every day
3 Yes, taken occasionally, especially in winter
4 No, I don't take vitamin D supplements
9 Don't know

ME03. [IF ME02=1,2,3] What is the dosage of the vitamin D supplements you take?
Dosage in IU number:

7. MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since March 2020 when COVID-19 was declared a pandemic and how the pandemic had an impact on your mental and emotional

status. ***Please note that a mental health professional will not follow-up with you if your responses to these questions suggest you are in distress.*** *If you are experiencing stress or anxiety and would like to access support, please reach out to mental health services available in your area.*

PI01. Since March 2020, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

PI02. [IF YES TO ANY ABOVE] How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

PI03. Since March 2020, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				

Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

PI04. [IF YES TO ANY ABOVE] How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

PI05. We would like you to compare your mental and emotional health before March 2020 to now.

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your current mental and emotional health is:	○	○	○	○	○

	Better	**About the Same**	**Worse**
Your current mental and emotional health now compared to before the pandemic is:	○	○	○

PI07. Since March 2020, have you accessed mental health services?

0 No – I did not need it
1 No – I was not comfortable seeking mental health support
2 No – My regular mental health professional was not accepting appointments
3 No – I could not find a new mental health professional that was accepting clients
4 No – I lost my health benefits (e.g., my hours were reduced and/or I was laid off)
5 No – I could not afford to access mental health services
6 Yes – Using resources that I already had in place
7 Yes – I have initiated new use of services
8 Other: _____
9 Prefer not to answer

10 Don't know

PI08. [IF PI07=6,7] Did you access mental health services for any of the following conditions?

Select all that apply.

1 Anxiety
2 Depression
3 Stress
8 Prefer not to answer
Other: Please specify

8. SOCIAL & ECONOMIC IMPACT

The March 2020 declaration and persistence of the global pandemic has devastated local communities and economies and many people lost their livelihoods. With these next set of questions, we want to understand how your family's ability to meet its essential needs and financial obligations have been impacted, and ask whether your family has given or received support in your community.

SI01. What is your current employment status?

Select all that apply. Full time means 30 hours or more per week. Part time means less than 30 hours per week.

1 Full-time employed / self-employed
2 Part-time employed / self-employed
3 Retired
4 Looking after home and/or family
5 Unable to work because of sickness or disability
6 Unemployed
7 Doing unpaid or voluntary work
8 Student

SI01W [IF SI01=1,2] In what sector do you work?

Code	**Sector**	
11	Agriculture, forestry, fishing and hunting	
21	Mining, quarrying, and oil and gas extraction	
22	Utilities	
23	Construction	

Code	**Sector**	
31-33	Manufacturing	
41	Wholesale trade	
44-45	Retail trade	
48-49	Transportation and warehousing	
51	Information and cultural industries	
52	Finance and insurance	
53	Real estate and rental and leasing	
54	Professional, scientific and technical services	
55	Management of companies and enterprises	
56	Administrative and support, waste management and remediation services	
61	Educational services	
62	Health care and social assistance	
71	Arts, entertainment and recreation	
72	Accommodation and food services	
81	Other services (except public administration)	
91	Public administration	

SI01_Bis. Since March 2020, have you worked or volunteered in any of the following positions:

- Hospital or healthcare facility worker (including long term care facilities)
- Health professional in community-based settings (not in hospital)
- Social and community service worker (outside of hospital or healthcare settings; includes services provided in private homes)
- First responder
- Correctional officer
- Other services requiring entry into private homes
- Teacher, school staff and childcare

- Transit/Shuttle driver
- Passenger and delivery drivers (e.g., Taxi, Uber, Limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries)
- Food service industry worker
- Grocery Store Worker
- Casino Worker
- Retail Store Worker
- Hairdresser/Barber
- Aesthetician
- Airline or Airport employee
- Factory Worker
- Farm Worker
- Oil and gas extraction staff

Yes
No [SKIP SI01_Ter]
Prefer not to answer [SKIP SI01_Ter]

SI01_Ter Please select all of following positions you have worked or volunteered in since March 2020.

	Select
Hospital or healthcare facility worker (including long term care facilities)	- Physician - Dentist - Dental Hygienist and Dental Therapist - Nurse - Physiotherapist/Occupational Therapist/Allied Health Professional in hospital setting - Medical Imaging Technicians - Healthcare Aide - Environmental Services Worker - Long term/Nursing Home Care Aide - Personal Support Worker - Social Worker - Dietician - Pharmacist - Other Pharmacy worker - Food Services - Administrative Worker in healthcare setting - Other – Please specify
Health Professional in Community-based Settings (not in hospital)	- Audiologist - Chiropractor - Dentist

	- Dietitian - Family Doctor or Specialist - Medical Imaging Technicians - Massage Therapist - Optometrist or Optician - ~~Public Health~~ Nurse - Pharmacist - Other Pharmacy worker - Physiotherapist - Psychologist or Counsellor - Speech Language Pathologist - Other – Please specify
Social and Community service worker (outside of hospital or healthcare settings; includes services provided in private homes)	- Social Worker - Personal Support Worker - Nurse - Home Care Aide - Physiotherapist/Occupational Therapist/Allied Health Professional - Community Aid/Shelter Worker - Other – Please specify
First Responder	- Paramedic - Firefighter - Police Officer - By-Law Officer - Other – Please specify
Correctional Officer	-
Other services requiring entry into private homes	- House cleaners - Movers - Trades (e.g. plumber, electrician, etc.) - Other – please specify
Teacher, school staff and childcare	- Elementary School Teacher/Teacher's Assistant - Secondary School Teacher/Teacher's Assistant - Post-Secondary School Instructor/Teacher's Assistant - Administrative Staff - School facilities Staff - Social and Community Service Worker - Childcare worker - Other – Please specify
Transit/Shuttle driver	-

Passenger and Delivery Drivers (E.g. Taxi, Uber, Limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries)	- Driver (e.g. Taxi, Uber, etc.) - Food Delivery (e.g. Skip the Dishes, restaurant deliveries, etc.) - Package Delivery (e.g. UPS, FedEx, etc.) - Other – please specify
Food Service Industry Worker	- Food and Beverage server - Cashier - Cleaning staff o Other – Please specify
Grocery Store Worker	-
Casino Worker	-
Retail Store Worker	-
Hairdresser/Barber	-
Aesthetician	-
Airline or Airport employee	- Flight Attendant - Pilot or Flight Engineer - Customer and Information Service Staff - Ground Crew - Security - Customs Officer - Cleaning Staff o Other – Please specify
Factory Worker	- Distribution centre worker - Meat packing plant worker - Other factory worker o Other – Please specify
Farm Worker	o
Oil and gas extraction staff	- Oil rig worker - Food worker in camp - Cleaning staff in camp o Other – Please specify

SI02. Has anything about your occupation changed because of the pandemic (e.g. working from home)?

0 No

1 Yes

SI03. [IF SI02=YES] Select all that apply.

1 Nature of work has changed
2 External workplace has changed
3 Work from home
4 Reduced wages or hours
5 Loss of employment
6 Redeployed into healthcare for pandemic response
7 Redeployed into other essential services for pandemic response
8 Other: Please specify
88 Prefer not to answer

SI05. Prior to the pandemic, what was your approximate total household income (from all sources) before taxes last year?

Please include the total income including salaries, pensions and allowances.

1 Less than $10,000
2 $10,000 - $24,999
3 $25,000 - $49,999
4 $50,000 - $74,999
5 $75,000 - $99,999
6 $100,000 - $149,999
7 $150,000 - $199,999
8 $200,000 or more
88 Prefer not to answer
99 Don’t know

SI06. Has your monthly household income been changed because of the COVID-19 pandemic?

1 Substantially decreased
2 Somewhat decreased
3 No change
4 Somewhat increased
5 Substantially increased

SI07. Have your household savings been changed because of the COVID-19 pandemic?

1 Substantially decreased
2 Somewhat decreased
3 No change
4 Somewhat increased
5 Substantially increased

SI08. Which of the following best describes the impact of COVID-19 on your ability to meet financial obligations or essential needs, such as rent or mortgage payments, utilities and groceries?

1 Major impact
2 Moderate impact
3 Minor impact
4 No impact

We'd like to ask you about receiving support during the pandemic.

SI15. Since March 2020, have you looked for help, aid or support (including from friends, family, community or government) because of the pandemic?

1 Yes
0 No
9 Don't know

SI16. Since March 2020, have you received help, aid or support (including from friends, family, community or government) because of the pandemic?

1 Yes
0 No
9 Don't know

SI17. [IF SI16=YES] what kind of help, aid, information or support did you receive and from whom?

Select all that apply.

	Emotional or psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods and donations (e.g. furniture, clothing)
Family (spouse, parent, other relatives)						
Friend(s) or Neighbour(s)						
Community or volunteer organization						
colleagues						
Professional (doctor, lawyer, teacher, counsellor, spiritual leader, financial advisor)						
General media						

	Emotional or psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods and donations (e.g. furniture, clothing)
(TV, internet, social media)						
Provincial or Federal Health authorities (e.g. help, information phone lines, websites, social media)						
Government (financial support, financial relief, resources)						

SI18. Do you currently use a mobile application that allows to track COVID-19 in order to limit its spread and to estimate risk levels of infection? (e.g., the mobile application of the Canadian government "COVID Alert")

Yes - I use "COVID Alert"
Yes - I use another mobile application
I used this type of mobile application but not anymore
No - I don't know this type of mobile application
No - I do not wish to use this type of mobile application
No - I would like to but I don't have the possibility to use this type of mobile application
Don't know

9. GENDER IDENTITY and ANTHROPOMETRICS

DE01. How old are you?

_____ years

DE03. What was your assigned sex at birth?

0 Male
1 Female

DE09. How would you describe your ethnicity or race? (check all that apply)

Arab (e.g., Egypt, Iraq, Jordan, Lebanon)

Black (e.g., African or Caribbean descent)
Chinese
Filipino
Indigenous person originating from North America
Japanese
Korean
Latin American/Hispanic
South Asian (e.g., India, Sri Lanka, Pakistan, Bangladesh)
Southeast Asian (e.g., Malaysia, Indonesia, Vietnam)
West Asian (e.g., Turkey, Iran, Afghanistan)
White (European descent)
Prefer to self-describe
Prefer not to answer

DE09_Bis. [If Indigenous selected in DE09] Which of the following groups do you belong to? (select all that apply)
First Nations
Inuit
Métis
Non-status First Nations
Other Indigenous – please specify
Prefer not to answer

DE09_Ter. [If Indigenous selected in DE09] Do you live on or off reserve?
On-reserve
Off-reserve
Prefer not to answer

To finish the questionnaire, we would like to collect some anthropometric measurements since the COVID-19 pandemic may have caused changes in your eating and activity habits.

AM01. How tall are you?
Please answer the question using feet and inches or centimeters.
value in cm:
or
value in feet and inches:

AM02. Are you able to stand up and weight?
Yes
No

AM03 [IF AM02=YES] How much do you weigh?
• Adjust your scale to zero.

• Step on the scale with your clothes off, or wear light clothing. Remember to remove your shoes. Make sure both feet are fully on the scale.
• Weight yourself.
• Record your weight in pounds or kilograms.
Pounds
OR
Kilograms

If you are experiencing psychological distress related to the current COVID-19 situation, here are some resources that may be helpful:

Protecting your well-being in the COVID-19 pandemic:

https://www.quebec.ca/en/health/health-issues/a-z/2019-coronavirus/protecting-your-well-being-in-the-covid-19-pandemic/

Free and confidential telephone consultation service (Government of Quebec):

Dial 811

Thank you for participating in this COVID-19 survey!