CaG COVID-19 FOLLOW-UP QUESTIONNAIRE 12 months
Version 2022-04-05 English

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

This is the last collection timepoint in CARTaGENE's COVID-19 Antibody Study. Thank you for continuing to take part in this important study that will investigate how levels of antibodies to COVID-19 may change over time.

This questionnaire must be completed within ONE WEEK of receipt. 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.

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.

COVID-19 DIAGNOSES

DG07. Since September 1st, 2021, do you think you currently have, or have had COVID-19?
1 Yes
2 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

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 : _____

DG03. Since September 1st, 2021, have you been tested for COVID-19 (including a nasal swab and/or blood testing)?

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? For serology/antibody testing please do not include the tests that are part of this study. A maximum of 8 tests can be reported. Please report all positive tests first, starting with your most recent test, followed by other results, to a maximum of 8.

1
2
3
4
5
6
7
8

DG03Ter. [Repeat DG03Ter-DG05-DG06bis-DG04 as needed] For your first test, what was the type of test?

1 Viral test (a nasal/throat swab or gargle test for current infection)
2 Antibody/serology test (blood test for past infection)
3 Rapid test (a rapid antigen test with results in 15-20 minutes)

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)
Don't know

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

Value (Number of days)

DG04R. 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

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 seasonal allergies, existing medical conditions, etc.*

Please also do not include symptoms you experienced due to getting the vaccine.

SY01. Have you had a fever since September 1st, 2021 (>38 °C)?

1 Yes
0 No
9 Don't know

SY03. [IF SY01=1] What was the highest temperature recorded?

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

Value in celcius or farenheit:

SY04. Since September 1st, 2021, 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 seasonal allergies, usual migraine or existing medical conditions (e.g., asthma). One answer per line is needed.

	0 No	1 Mild	3 Severe
Dry cough			
Wet cough (cough that produces mucus)			
Runny nose			
Sinus pain			
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 INCLUDING FEVER] 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)

SY04Ter. [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)

SY05new. IF YES TO ANY SYMPTOMS] Do you continue to experience COVID-19 symptoms or complications?

1 Yes
0 No
9 Don't know

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			

SY09Bis [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												

COVID-19 - CARE/HOSPITAL RELATED INFORMATION

CH01. Since January 1st 2021, were you hospitalized because of COVID-19?

1 Yes
0 No
9 Don't know

CH02. [IF CH01=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 =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=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=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

LONG COVID

The previous questions asked you about a COVID-19 infection and symptoms since September 1, 2021. However, there is increasing evidence that some people who have had COVID-19 continue to experience lasting effects, sometimes called 'Long COVID' or 'Post COVID-19 Syndrome'. The following questions aim to capture longer lasting symptoms and impacts.

LC01. Have you ever had a COVID-19 infection?

Yes
No
Prefer not to answer

LC02. [IF YES TO LC01] When did you have COVID-19 (i.e., the active infection)?

If you have had COVID-19 more than once, please focus your answers on the longest episode of illness you have experienced.

3 months ago or less
Between 3 and 6 months ago
Between 6 and 9 months ago
Between 9 and 12 months ago
More than 12 months (1 year) ago
Don't know

LC03. How long have you had / did you have COVID-19 symptoms overall?

Please include time spent with mild symptoms and the time in between symptoms if these have been coming and going. If you have had COVID-19 more than once, please choose the duration for the same (longest) episode of illness you described in the previous question.

Less than 2 weeks
2-3 weeks

4-12 weeks
More than 12 weeks
Prefer not to answer

LC04. [IF 4-12 weeks or More than 12 weeks selected in LC03] Which of the following symptoms have you experienced for more than 1 month after infection?
Please only consider symptoms that are not explained by another reason, and select all that apply.

	No	Yes – Mild	Yes – Severe
Headache			
Chronic Fatigue			
Shortness of breath or difficulty breathing			
Persistent cough			
Muscle aches/pains or weakness			
Loss of smell or taste			
Memory problems (e.g. brain fog, difficulty concentrating)			
Mental health concerns (e.g. anxiety, depression)			
Difficulty sleeping			
Heart problems (e.g. chest pain, fast heartbeat)			
Gastrointestinal upset (e.g. nausea, diarrhea) Other			

LC05. Please specify other symptoms (If "other in LC04)

Other symptoms:

LC07. [IF YES in LC01]. Please select the best option for how much you feel fully recovered from COVID-19:
Strongly disagree (i.e., still experiencing significant symptoms/effects)
Disagree

Neither disagree nor agree (i.e., mostly recovered but still experiencing some symptoms/effects)
Agree
Strongly Agree (i.e., fully recovered and not experiencing any symptoms/ effects)

LC08. [If YES in LC01] Please assess the impact of your COVID-19 infection on your:

	No impact	Mild impact	Moderate impact	Severe impact	Extreme impact	Not applicable
Personal activities (e.g., grocery shopping, gardening)						
Family life						
Professional life						
Social life						
Morale/mood						
Relationship with caregivers						

VACCINATION

OT05. Have you received a vaccine against COVID-19?
Yes
No

OT06. Which vaccine did you receive?
Pfizer and BioNTech mRNA vaccine (Comirnaty)
Moderna mRNA vaccine (Spikevax)
AstraZeneca Oxford / Covishield vaccine (Vaxzevria)
Janssen (Johnson & Johnson) vaccine
Other: ____
Don't know

OT07. How many doses of the [OT06 Vaccine Name] vaccine did you receive?
One dose
Two doses
Three doses
Four doses

OT08. [Repeat as many times as is indicated in OT07.] When did you receive the 1st/2nd/3rd … 4th dose of the [OT06 Vaccine Name] vaccine?
(YYYYMMDD)

OT08A [Repeat as many times as is indicated in OT07.] In what setting did you receive the dose of the [OT06 Vaccine Name] vaccine?
Hospital
Public health clinic (ex: vaccination center)
Pharmacy
Nursing station
Physician office
Long-term care home
Workplace
Other – please specify (open text)

OT08B. Did you experience any side-effects (within the first few days) after receiving any dose of the COVID-19 vaccine?
Yes
No
Prefer not to answer

[IF YES to OT08B] OT08D. Did you experience the following other side-effects?

	No	Mild	Moderate	Severe	Prefer not to answer
Fatigue					
Headache					
Fever ≥38°C					
Chills or shivering					
Muscle aches/pains					
Sore throat					
Difficulty swallowing					
Shortness of breath or difficulty breathing					
Wheezing					
Chest pain					

Fast heartbeat
Blurry vision
Dizziness or light-headed
Abdominal pain
Nausea
Vomiting
Diarrhea
Rash, redness, or hives on other places on your body (other than the arm where you had the needle)
Swelling of other places on your body (other than the arm where you had the needle)
Numbness (in places of your body other than the arm where you had the needle)
Prickling or tingling (in places of your body other than the arm where you had the needle)

Repeat OT08C for as many vaccine doses as the participant has received

Q0r839. Did you experience any other side-effects or adverse events not mentioned above?

No
Yes – please specify (open text)

OT09 [do not show if OT05=Yes] Would you be willing to take a vaccine against COVID-19?

Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
Prefer not to answer

OT09A What are the main concerns you have around getting the vaccine (Select all that apply)?
If you have already received the vaccine, what were your main concerns?
No concerns about getting the vaccine
I am worried about unknown future effects of the vaccine
I am worried about side-effects
Vaccines are limited and other people need it more than me
I don't trust vaccines
I previously tested positive for COVID-19 and so should have protection
The chances of me becoming seriously unwell from COVID-19 are low
The chances of me catching COVID-19 are low
The impact of COVID-19 is being greatly exaggerated
I don't think it would be effective at preventing me from catching COVID-19
I have a condition which would make it unsafe for me
Herd immunity will protect me even if I don't have the vaccine
It's not offered at a location that is easy for me to get to
Other – please specify (open text)

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

RISK FACTORS

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)

RF04new2. 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

RF06new. At the present time, are you using cannabis?

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

6. MEDICAL CONDITIONS

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.

CANCEROCCURENCE. Since March 2021, 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?
Bladder	1 Yes 0 No 9 Don't know
Breast	1 Yes 0 No 9 Don't know
Cervix	1 Yes 0 No 9 Don't know
Colon	1 Yes 0 No 9 Don't know
Esophagus	1 Yes 0 No 9 Don't know
Kidney	1 Yes 0 No 9 Don't know
Larynx	1 Yes 0 No 9 Don't know
Leukemia	1 Yes 0 No 9 Don't know
Liver	1 Yes 0 No 9 Don't know
Lung and bronchus	1 Yes 0 No 9 Don't know
Lymphoma (Hodgkin Lymphoma)	1 Yes 0 No 9 Don't know

Type of Cancer	Are you currently undergoing treatment?
Lymphoma (non-Hodgkin Lymphoma)	1 Yes 0 No 9 Don't know
Mouth, tongue or throat	1 Yes 0 No 9 Don't know
Multiple myeloma	1 Yes 0 No 9 Don't know
Ovary	1 Yes 0 No 9 Don't know
Pancreatic	1 Yes 0 No 9 Don't know
Prostate	1 Yes 0 No 9 Don't know
Rectum	1 Yes 0 No 9 Don't know
Skin (Melanoma)	1 Yes 0 No 9 Don't know
Skin (Non-Melanoma)	1 Yes 0 No 9 Don't know
Small intestine	1 Yes 0 No 9 Don't know
Stomach	1 Yes 0 No 9 Don't know
Testicle	1 Yes 0 No 9 Don't know
Thyroid	1 Yes 0 No 9 Don't know
Uterus	1 Yes 0 No

Type of Cancer	Are you currently undergoing treatment?
	9 Don't know
Other: _____	1 Yes 0 No 9 Don't know

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

Condition	Diagnosed
Diabetes	1 Yes 0 No 9 Don't know If yes, which type of diabetes was it? Type 1 diabetes Type 2 diabetes
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)
	Heart attack (myocardial infarction)
	Heart failure
	Atherosclerosis / Coronary heart disease (including angioplasty or stents)
	Atrial fibrillation
	Angina
	Heart murmur
	Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)
Respiratory system conditions	1 Yes 0 No 9 Don't know

Condition	Diagnosed
	If yes, select all that apply:
	Asthma
	Chronic obstructive pulmonary disease (COPD)
	Interstitial lung disease
	Chronic bronchitis
	Cystic fibrosis
	Emphysema
	Sleep apnea
Gastrointestinal conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:
	Crohn's disease
	Ulcerative colitis
	Irritable bowel syndrome
	Celiac disease
	Stomach ulcers
	Persistent acid reflux/Gastroesophageal reflux disease (GERD)
Liver or pancreas conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:
	Liver cirrhosis
	Chronic hepatitis
	Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)
	Gallstones
Renal disease / kidney failure conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:
	Acute renal failure

Condition	Diagnosed
	Chronic renal failure
	Kidney stones
Mental health condition	1 Yes 0 No 9 Don't know If yes, select all that apply:
	Major depression
	Minor depression
	Bipolar disorder
	Post-traumatic stress disorder
	Schizophrenia or Schizoaffective disorder
	Obsessive compulsive disorder
	Anxiety disorder
	Eating disorder
	Addiction disorder (e.g. alcohol, drug or gambling dependence)
Neurological conditions	1 Yes 0 No 9 Don't know If yes, select all that apply:
	Thrombotic stroke
	Hemorrhagic stroke
	Multiple sclerosis
	Migraines
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): _____
Bone and joint conditions	1 Yes

Condition	Diagnosed
	0 No 9 Don’t know If yes, select all that apply:
	Lupus
	Fibromyalgia
	Osteoporosis
Skin conditions	1 Yes 0 No 9 Don’t know If yes, select all that apply:
	Eczema
	Rosacea
	Psoriasis
	Scleroderma
Immune system conditions	1 Yes 0 No 9 Don’t know If yes, select all that apply:
	HIV
	A weakened or compromised immune system such as Severe Combined Immunodeficiency
	Hashimoto's thyroiditis, Sjögren’s syndrome, or Ankylosing spondylitis
Other (up to 3 ‘other’ conditions can be entered)	1 Yes 0 No 9 Don’t know Text box

MC07N. Since March 2021, 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
Cancelled/deferred 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 cancelled/deffered in 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:

MC09. Are you currently taking, or have you taken in the past 12 months, an immunosuppressive or immunomodulatory medication (e.g., corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)
|_| No
|_| Yes – currently taking each day
|_| Yes – taken within the last few months (during the COVID-19 pandemic) but not every day
|_| Taken before March 2021 but currently
|_| Don't know

MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since September 2021. ***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 September 1st, 2021, 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 September 1st, 2021, 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

PI07new. Since March 1st, 2021, 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

OTHER

SI01BisNew. Since March 2021, 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
|_| Prefer not to answer

SI01TERcat. [If SI01BisNew = Yes] Please select all of the following positions you have worked or volunteered in since March 2021.
Please check the category(ies) of employment. ***Select all that apply:***

|_| 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

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.
|_| Less than $10,000
|_| $10,000 - $24,999
|_| $25,000 - $49,999
|_| $50,000 - $74,999
|_| $75,000 - $99,999
|_| $100,000 - $149,999
|_| $150,000 - $199,999
|_| $200,000 or more
|_| Prefer not to answer
|_| Don't know

SI06. Has your monthly household income been changed because of the COVID-19 pandemic?
|_| Substantially decreased
|_| Somewhat decreased
|_| No change
|_| Somewhat increased
|_| Substantially increased

SI07. Have your household savings been changed because of the COVID-19 pandemic?
|_| Substantially decreased
|_| Somewhat decreased
|_| No change
|_| Somewhat increased
|_| Substantially increased

SI08new. 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?
|_| Major impact
|_| Moderate impact
|_| Minor impact
|_| No impact
|_| Too soon to tell

ANTHROPOMETRICS

To finish the questionnaire, we would like to collect some anthropometric measurements.

AM01. What is your height?
Please answer the question using feet and inches or centimeters. If entering your height in feet and inches, please include a number for BOTH feet and inches.
Feet_____ & Inches _____
Centimetres_____
|_| Prefer not to answer
|_| Don't know

AM02. How much do you weigh?

- ***Adjust your scale to zero;***
- ***Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.***
- ***Step on the scale. Make sure both feet are fully on the scale.***
- ***Record your weight in pounds or kilograms.***

Pounds_____
Kilograms_____
|_| Prefer not to answer
|_| Don't know

7. DEMOGRAPHIC INFORMATION

A5. In which region do you currently live?
1 Abitibi Témiscamingue
2 Bas-Saint-Laurent
3 Capitale-Nationale
4 Chaudière-Appalaches
5 Côte-Nord
6 Estrie
7 Gaspésie et les Iles-de-la-Madeleine
8 Laval
9 Lanaudière
10 Laurentides
11 Montérégie
12 Montréal
13 Nord-du-Québec
14 Nunavut
15 Outaouais
16 Saguenay-Lac-Saint-Jean
17 Terres-Cries-de-la-Baie-James
18 I live in Canada, but outside of Québec

19 I don’t 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:

Thank you for participating in this COVID-19 survey!