CaG COVID-19 FOLLOW-UP QUESTIONNAIRE 6 months
Version 2021-06-04 English

Thank you for completing the CARTaGENE COVID-19 Blood Spot questionnaire and providing your blood spot sample for COVID-19 antibodies analysis.

This shorter questionnaire is designed to learn about changes to your health, both physical and mental, from the impact of COVID-19 since you completed the last questionnaire.

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.

1. COVID-19 DIAGNOSES

DG03. Since January 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. If you have had >8 tests, please provide the information for your most recent tests.

1
2
3
4
5
6
7
8

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

Viral test (a nasal/throat swab or gargle test 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, or have had since January 1, 2021, 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. VACCINATION

OT04. Is a vaccine to COVID-19 available to you now?
Yes
No
Don't know

OT05 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 (go to OT05B)
No (skip to OT09)

OT05B Did you receive this vaccine in Quebec?
Yes [SKIP to DG15]
No [Go to OT05C]

[IF NO to OT05B] OT05C Where did you receive this vaccine (province/state, or country)?
Open text

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? Select all that apply.
Pfizer and BioNTech mRNA vaccine
Moderna mRNA vaccine
AstraZeneca Oxford / Covishield vaccine
Janssen (Johnson & Johnson) vaccine
Other: ____
Don't know

OT07. How many doses of the [OT06 Vaccine Name] vaccine 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
Four doses
Five doses
Six doses

OT08. [Repeat as many times as is indicated in OT07.] When did you receive the 1st/2nd/3rd … 6th 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
Pharmacy
Nursing station
Physician office
Long-term care home
Workplace clinic
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 [Go to OT08C]
No [SKIP to OT09A]
Prefer not to answer

[IF YES to OT08B] OT08C. Did you experience the following side-effects in the arm where you had the needle?

	No	Yes - Mild	Yes - Moderate	Yes - Severe	Prefer not to answer
Redness					
Itching/hives					
Prickling/tingling					
Soreness					
Pain					
Swelling					
Bruising					

[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)

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

No
Yes – please specify (open text)

[If Mild/Moderate/Severe to any symptoms in OT08C or OT08D] OT08E. Did you contact a healthcare provider about these symptoms?
Yes
No
Prefer not to answer

[If Mild/Moderate/Severe to any symptoms in OT08C or OT08D] OT08F. Did you require hospitalization for these symptoms?
Yes
No
Prefer not to answer

[If Mild/Moderate/Severe to any symptoms in OT08C or OT08D] OT08G. How long did these symptoms last?
___ days

[If YES to OT05] OT08H. Have you experienced allergic reactions to these items in the past?

	Yes	No	Don't know	Prefer not to answer
Other vaccines (e.g. flu shot)				
Medications				
Food				

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

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

We are interested in the reasons why people choose to get the vaccine or not.

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)

OT09B. What are your main reasons for getting the vaccine (select all that apply)? (If you have already received the vaccine, what were your main reasons?)
To stop me from catching COVID-19 or getting very ill from it
To allow my social and family life to get back to normal
To protect other people from catching COVID-19
Because the vaccine won't work unless most people take it
Because I work in an essential service setting
Because I am in contact with people with higher risk
Because it is/was recommended by my healthcare provider
Because it is/was recommended by public health experts
Because it is/was recommended by the government
To allow me to go out of my home safely again
To reduce the disruption to my children's education
To allow me to return to my workplace
To allow me to get the help or care I need at home
Not applicable – I do not plan on getting the vaccine
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

3. 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.*

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

SY01. Have you had a fever since January 1st, 2021 (>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, 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 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				
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:

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												

4. 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

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

5. COVID-19 – EXPOSURE

EX04. How many times have you been in a social gathering (apart from work) of more than 10 people since January 1st, 2021? 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

For the next question, please use the following definition:
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 January 1st, 2021, 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					

	Never	Rarely	Occasionally	Often	Always
physical distancing in public places					
Avoided crowded places/gatherings					
Avoided common greetings (e.g., shaking hands, hugging)					
Limited contact 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					

	Never	Rarely	Occasionally	Often	Always
exposed to COVID-19, but did not show symptoms					
Self-quarantined because you thought you were infected with COVID-19					
Worked from home					
Stocked up on essentials at a grocery store or pharmacy					
Wore gloves when going out in public					

Other: Please specify

6. RISK FACTORS

E5. Compared to the beginning of 2021, have you changed your level of physical activity?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E6. Compared to the beginning of 2021, has your sleep duration changed?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E6_Bis. Compared to bthe beginning of 2021, has the quality of your sleep changed ?

Substantially increased
Somewhat increased
No change

Somewhat decreased
Substantially decreased

E7. Compared to the beginning of 2021, has the quality of your food changed?

Substantially increased
Somewhat increased
No change
Somewhat decreased
Substantially decreased

E7_Bis. Compared to the beginning of 2021, has your food intake changed?

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 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

7. MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since January 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 January 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 January 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

PI05. We would like you to compare your mental and emotional health before January 1st, 2021 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 January 1st, 2021 is:		○	○		○

PI07. Since January 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

8. DEMOGRAPHIC INFORMATION

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

Thank you for participating in this COVID-19 survey!