



**COVID-19 INFECTION SURVEY: CRF4 INDIVIDUAL PARTICIPANT
– COMPLETE AT ENROLMENT FOR EACH CONSENTING PARTICIPANT**

IF COMPLETING FOR A CHILD BY A PARENT/CARER PROXY, REMEMBER “YOU” IS THE PARTICIPANT

Unique house- hold code																					Participant date of birth	D	D	M	M	M	Y	Y	Y	Y																							
Unique part- icipant code																					Date/time of visit	D	D	M	M	M	2	0	2	Y	h	h	:	m	m																		
Swab <input type="checkbox"/> Yes taken <input type="checkbox"/> No	If yes: barcode																				If yes: shipment ID																																
Blood <input type="checkbox"/> Yes taken <input type="checkbox"/> No	If yes: barcode																				If yes: shipment ID																																
Date/time samples taken																					D	D	M	M	M	Y	Y	Y	Y	h	h	:	m	m																			

A: RECORDING OF SIGNED CONSENT OPTIONS FROM ICF

1. Did the participant consent to join the study (Q1-Q5 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did the participant consent to 5 visits (enrolment plus 4 follow-up) (Q6 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did the participant consent to visits until end of the study (Q7 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did the participant consent to be approached for other studies (Q8 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. <i>If blood and swab household:</i> Is the participant 16y or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes to Q5:</i> (a) Did they consent to fingerprick samples (Q9 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) <i>If yes:</i> did they consent to future use of blood samples (Q10 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. <i>If swab ONLY household:</i> Is the participant 16y or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes to Q6:</i> (a) Did they consent to blood samples if someone in their household tests positive for COVID-19 on a nose and throat swab (Q9 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) <i>If yes:</i> did they consent to future use of blood samples (Q10 on consent form)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

B: DEMOGRAPHICS

1. What is your sex? <input type="checkbox"/> Male <input type="checkbox"/> Female
2. What is your ethnic group? <i>White</i> (<i>select one</i>)
<input type="checkbox"/> English, Welsh, Scottish, Northern Irish or British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy or Irish Traveller
<input type="checkbox"/> Any other white background, specify _____
<i>Mixed / multiple ethnic groups</i>
<input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian
<input type="checkbox"/> Any other Mixed/multiple background, specify: _____
<i>Asian or Asian British</i>
<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese
<input type="checkbox"/> Any other Asian background, specify: _____
<i>Black, African, Caribbean or Black British</i>
<input type="checkbox"/> African <input type="checkbox"/> Caribbean
<input type="checkbox"/> Any other Black, African or Caribbean background, specify: _____
<i>Other ethnic group</i>
<input type="checkbox"/> Arab
<input type="checkbox"/> Any other ethnic group, specify _____

C: WORK, SCHOOL AND NURSERY

1. What is your current work, education or other status, that is, where you spend most of your time? (<i>select one</i>)
<input type="checkbox"/> Employed and currently working (including if on leave or sick leave for less than 4 weeks) (<i>go to C3</i>)

<input type="checkbox"/> Employed and currently not working (e.g. on leave due to the COVID-19 pandemic (furloughed); sick leave for 4 weeks or longer, or maternity/paternity leave)	(go to C3)
<input type="checkbox"/> Self-employed and currently working (include if on leave or sick leave for less than 4 weeks)	(go to C3)
<input type="checkbox"/> Self-employed and currently not working (e.g. on leave due to the COVID-19 pandemic; sick leave for 4 weeks or longer or maternity/paternity leave)	(go to C3)
<input type="checkbox"/> Looking for paid work and able to start	(go to Section D)
<input type="checkbox"/> Not in paid work and not looking for paid work (include doing voluntary work here)	(go to Section D)
<input type="checkbox"/> Retired (include doing voluntary work here)	(go to C2)
<input type="checkbox"/> Child under 4-5y not attending nursery, pre-school, childminder	(go to Section D)
<input type="checkbox"/> Child under 4-5y attending nursery, pre-school, childminder	(go to C8)
<input type="checkbox"/> 4-5y and older at school/home-school (including if temporarily absent)	(go to C2 if 16y or older, otherwise C8)
<input type="checkbox"/> Attending college or other further education provider (including apprenticeships) (including if temporarily absent)	(go to C2)
<input type="checkbox"/> Attending university (including if temporarily absent)	(go to C2)
2. Do you have any paid employment in addition to this, or as part of an apprenticeship?	
<input type="checkbox"/> Yes (go to C3)	<input type="checkbox"/> No (go to C8 if 16y and older in education: go to Section D if Retired)
3. <u>If currently working at all, or currently employed/self-employed but not working at the moment:</u>	
(a) What is the title of your main job or business? (e.g. primary school teacher, car mechanic, district nurse, structural engineer etc.)	
(b) What do you mainly do in your main job or business? (please describe as fully as possible. For example, please indicate if you have any management responsibilities)	
(c) Which of these employment sectors do you work in? (select one)	
<input type="checkbox"/> Teaching and education	<input type="checkbox"/> Health care (go to C4)
<input type="checkbox"/> Social care (go to C5)	<input type="checkbox"/> Transport (incl. storage, logistic)
<input type="checkbox"/> Retail sector (incl. wholesale)	<input type="checkbox"/> Hospitality (e.g. hotel, restaurant, cafe)
<input type="checkbox"/> Food production and agriculture (incl. farming)	<input type="checkbox"/> Personal services (e.g. hairdressers, tattooists)
<input type="checkbox"/> Information technology and communication	<input type="checkbox"/> Financial services (incl. insurance)
<input type="checkbox"/> Manufacturing or construction	<input type="checkbox"/> Civil service or Local Government
<input type="checkbox"/> Armed forces	<input type="checkbox"/> Arts, entertainment or recreation
<input type="checkbox"/> Other employment sector, specify _____	(go to C6 if not working in Health or Social care)
4. <u>If 'Health care':</u> Is that currently (select one) <input type="checkbox"/> Primary care, e.g. GP, dentist <input type="checkbox"/> Secondary care, e.g. hospital <input type="checkbox"/> Other healthcare, e.g. mental health	
5. Do you currently work in a nursing care home or a residential care home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Does your current role primarily involve direct contact, in person, with patients/clients/residents/service users/customers on a day-to-day basis? (Please answer 'no' if primarily office-based) <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. <u>If currently working now</u> (see C1, C2): Currently, do you work (select one)	
<input type="checkbox"/> From home (in the same grounds or building as your home)	(go to Section D)
<input type="checkbox"/> Somewhere else (not at your home)	(go to C8)
<input type="checkbox"/> Both (work from home and work somewhere else)	(go to C8)
8. <u>If currently working not at your home, or in education or attending school/nursery, etc:</u> On average, on how many days of the week are you currently working somewhere else (not at your home, defined as the same grounds or building as your home), or currently attending, in person, your place of education, school, nursery, pre-school or childminder? (select one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
9. <u>If currently working not at your home, or in education or attending school or nursery, etc:</u> How do you mainly get to and from work/nursery/education provider? (select one only: if use multiple modes, choose the longest part of your journey in time)	
<input type="checkbox"/> Underground, metro, light rail, tram	<input type="checkbox"/> Train
<input type="checkbox"/> Car or van	<input type="checkbox"/> Taxi/minicab
<input type="checkbox"/> Bus, minibus, coach	<input type="checkbox"/> Motorbike, scooter or moped
<input type="checkbox"/> Bicycle	<input type="checkbox"/> On foot
<input type="checkbox"/> Other method	
10. <u>If currently working or in education or attending school or nursery, etc:</u> On average how easy is it to maintain 1-2m between yourself and other people at your place of work/education/school/nursery, etc? (select one)	
<input type="checkbox"/> Easy to maintain 2m, it is not a problem to stay this far away from other people	
<input type="checkbox"/> Relatively easy to maintain 2m, most of the time you can be 2m away from other people	
<input type="checkbox"/> Difficult to maintain 2m, but you can usually be at least 1m from other people	
<input type="checkbox"/> Very difficult to be more than 1m away, as your work means you are in close contact with others on a regular basis	

D: YOUR HEALTH STATUS TODAY

1. Have you had any of these symptoms in the last 7 days ?																				
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weakness/tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No									
Diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea/vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No									
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of smell	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No									
(a) Please confirm: have you had any of these symptoms in the last 7 days ? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
(b) <i>If yes</i> : date first symptom onset: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>2</td><td>0</td><td>2</td><td>Y</td> </tr> </table>												D	D	M	M	M	2	0	2	Y
D	D	M	M	M	2	0	2	Y												
2. Are you currently self-isolating due to COVID-19 (meaning you are not leaving your home)? (<i>select one</i>)																				
<input type="checkbox"/> No																				
<input type="checkbox"/> Yes because you have/have had symptoms of COVID-19 or a positive test																				
<input type="checkbox"/> Yes because you live with someone who has/had symptoms or a positive test, but you haven't had symptoms yourself																				
<input type="checkbox"/> Yes, for other reasons related to you having had an increased risk of getting COVID-19 (e.g. having been in contact with a known case, quarantining after travel abroad)																				
<input type="checkbox"/> Yes, for other reasons related to reducing your risk of getting COVID-19 (e.g. going into hospital, shielding)																				
3. Do you currently think you have symptoms consistent with COVID-19 infection? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
4. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more (excluding any long-lasting COVID-19 symptoms)? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
<i>If yes</i> : (a) Do any of your conditions or illnesses reduce your ability to carry-out day-to-day activities? (<i>select one</i>)																				
<input type="checkbox"/> Yes, a lot <input type="checkbox"/> Yes, a little <input type="checkbox"/> Not at all																				
5. Have you ever smoked cigarettes regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
6. Do you currently smoke or vape at all? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
<i>If yes</i> : (a) please tick all that apply: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> Vape/e- cigarettes <input type="checkbox"/> Hookah/shisha pipes																				

E: CONTACT WITH OTHER PEOPLE

1. In the last 28 days, have you been in direct contact, in person, with someone that you <u>definitely know</u> , because they had a positive test result, was infected with COVID-19 at the time you were in contact with them? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
<i>If yes</i> : (a) Date of last contact of this type: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>2</td><td>0</td><td>2</td><td>Y</td> </tr> </table>												D	D	M	M	M	2	0	2	Y
D	D	M	M	M	2	0	2	Y												
(b) Was this last person you had this type of contact with <input type="checkbox"/> living in your own home <input type="checkbox"/> outside your home																				
2. In the last 28 days, have you been in direct contact, in person, with someone that you <u>think</u> was infected with COVID-19 at the time you were in contact with them – this could include: someone who has not been tested; someone who has been tested but you do not know the result; or someone who has tested negative? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
<i>If yes</i> : (a) Date of last contact of this type: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>2</td><td>0</td><td>2</td><td>Y</td> </tr> </table>												D	D	M	M	M	2	0	2	Y
D	D	M	M	M	2	0	2	Y												
(b) Was this last person you had this type of contact with <input type="checkbox"/> living in your own home <input type="checkbox"/> outside your home																				
3. In the last 28 days, have <u>you</u> been inside a hospital for any reason (e.g. for work, for a consultation or treatment, to visit someone, to take someone else)? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
<i>If no</i> : (a) In the last 28 days, has <u>anyone that you usually live with</u> been inside a hospital at all for any reason (e.g. for work, for consultation or treatment, to visit someone, to take someone else)? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
4. In the last 28 days, have <u>you</u> been inside a care/residential home for any reason (e.g. for work, to visit someone, to take someone else)? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
<i>If no</i> : (a) In the last 28 days, has <u>anyone that you usually live with</u> been inside a care/residential home at all (e.g. for work, to visit someone, to take someone else)? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
5. In the last 7 days, how many hours a day on average have you spent within 2m of someone else in your home, including sleeping? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> </table>																				
6. Over the last 7 days, how many <u>children and young adults <18y</u> not living in your home have you had physical contact with (e.g. handshake, personal care), including with PPE if you wear it? (<i>select one</i>)																				
<input type="checkbox"/> 0 <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21 or more																				
7. Over the last 7 days, how many <u>adults 18-69y</u> not living in your home have you had physical contact with (e.g. handshake, personal care), including with PPE if you wear it? (<i>select one</i>)																				
<input type="checkbox"/> 0 <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21 or more																				
8. Over the last 7 days, how many older <u>adults 70y</u> and over not living in your home have you had physical contact with (e.g. handshake, personal care), including with PPE if you wear it? (<i>select one</i>)																				
<input type="checkbox"/> 0 <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21 or more																				
9. Over the last 7 days, how many <u>children and young adults <18y</u> not living in your home have you had direct, <u>but not physical</u> , contact with in person, e.g. with social distancing only? (<i>select one</i>)																				
<input type="checkbox"/> 0 <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21 or more																				

10. Over the last 7 days, how many adults 18-69y not living in your home have you had direct, but not physical, contact with in person, e.g. with social distancing only? (*select one*)
 0 1-5 6-10 11-20 21 or more

11. Over the last 7 days, how many older adults 70y and over not living in your home have you had direct, but not physical, contact with in person, e.g. with social distancing only? (*select one*)
 0 1-5 6-10 11-20 21 or more

12. In the last 7 days, how many times have you spent one hour or longer inside the buildings of another person's home? (*select one*)
 None 1 2 3 4 5 6 7 times or more

13. In the last 7 days, how many times has someone who doesn't live with you spent one hour or longer inside the buildings of your home? (*select one*)
 None 1 2 3 4 5 6 7 times or more

14. In the last 7 days, how many times have you been outside of your home for shopping? (*select one*)
 None 1 2 3 4 5 6 7 times or more

15. In the last 7 days, how many times have you been outside of your home to socialise, including visiting restaurants, etc? (*select one*)
 None 1 2 3 4 5 6 7 times or more

16. Do you wear any kind of face covering or mask when you are at work/your place of education, because of COVID-19? (*select one*)
 Not going to place of work or education Yes, always Yes, sometimes Never
 My face is already covered for other reasons (e.g. religious or cultural reasons)

17. Do you wear any kind of face covering or mask when you are in other enclosed public spaces, such as shops, or using public transport, because of COVID-19? (*select one*)
 Not going to other enclosed public spaces or using public transport
 Yes, always Yes, sometimes Never
 My face is already covered for other reasons (e.g. religious or cultural reasons)

F: COVID-19 INFECTION AND YOU

1. Do you know or think that you have had COVID-19? (*if not sure, select No*) Yes No

If yes: (a) On what date did you first know or think you had COVID-19:

D	D	M	M	M	2	0	2	Y
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(b) Did you have any symptoms when you first knew or thought you had COVID-19? Yes No

(c) *If yes:* Did you have any of the following symptoms when you first had COVID-19? (answer Yes or No for each one)

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weakness/tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea/vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of smell	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(d) Did you contact the NHS when you thought you had COVID-19 (e.g. 111, GP, Walk-in Centre, A&E)?
 Yes No

(e) Were you admitted to hospital when you thought you had COVID-19?
 Yes No

2. Have you ever had a swab test of your nose and throat to test for COVID-19 infection? Yes No

If yes: (a) What was the result/were the results of all swab tests you've had? (*select one*)

One or more positive test(s) One or more negative tests, but none were positive
 All tests failed Waiting for all results

(b) *If any test positive:* What was the date of first positive test you've had?

D	D	M	M	M	2	0	2	Y
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(c) *If all tests negative:* What was the date of last negative test you've had?

D	D	M	M	M	2	0	2	Y
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3. *If yes to Q2: had a swab test of your nose and throat to test for COVID-19 infection.* Are you regularly testing yourself for COVID-19 using a lateral flow test: that's the test you can do yourself and you do not have to send it to a laboratory because the result shows in the device in around about 30 minutes?
 Yes No

4. Have you ever had a blood test to test for COVID-19 antibodies? Yes No

If yes: (a) What was the result/were the results of all blood tests you've had? (*select one*)

One or more positive test(s) One or more negative tests, but none were positive
 All tests failed Waiting for all results

(b) Where was the test done? (*if more than one test, provide for the most recent positive test, otherwise the most recent negative test, otherwise the most recent test*)
 In the NHS (e.g. GP, hospital) Private lab Home test

(c) *If any tests positive:* What was the date of first positive test you've had?

D	D	M	M	M	2	0	2	Y
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(d) *If all tests negative:* What was the date of last negative test you've had?

D	D	M	M	M	2	0	2	Y
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5. Would you describe yourself as having "long COVID", that is, you are still experiencing symptoms more than 4 weeks after you first had COVID-19, that are not explained by something else? Yes No

