



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

Form fields for Unique household code, Participant date of birth, Unique participant code, Date/time of visit, Swab taken, Blood taken, and Date/time samples taken.

A: RECORDING OF SIGNED CONSENT OPTIONS FROM ICF

Consent questions 1-6 regarding study participation, visits, and sample use.

B: DEMOGRAPHICS

Demographic questions 1-2 regarding sex and ethnic group.

C: WORK, SCHOOL AND NURSERY

Work, school, and nursery question 1 regarding current status.

<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 generally work (select one: if currently self-isolating, choose where you would usually work when not self-isolating)	
<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: if currently self-isolating, choose where you would usually work when not self-isolating)	
<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"/> Bus, minibus, coach	<input type="checkbox"/> Motorbike, scooter or moped
<input type="checkbox"/> Car or van	<input type="checkbox"/> Taxi/minicab
<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 (including high temperature) <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	More trouble sleeping than usual <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of appetite or eating less than usual <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	Runny nose/sneezing <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	Noisy breathing (wheezing) <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		

(a) Please confirm: have you had any of these symptoms **in the last 7 days?** Yes No

(b) *If yes:* what was the earliest date that any of these symptoms first started or became worse than usual for you?

D	D	M	M	M	2	0	2	Y
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2. Are you currently self-isolating due to COVID-19 (meaning you are not leaving your home)? (*select one*)

No

Yes because you have/have had symptoms of COVID-19 or a positive test

Yes because you live with someone who has/had symptoms or a positive test, but you haven't had symptoms yourself

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)

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? Yes 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)? Yes No

If yes: (a) Do any of your conditions or illnesses reduce your ability to carry-out day-to-day activities? (*select one*)

Yes, a lot Yes, a little Not at all

5. Have you ever smoked cigarettes regularly? Yes No

6. Do you currently smoke or vape at all? Yes No

If yes: (a) please tick all that apply: Cigarettes Cigar Pipe Vape/e- cigarettes 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 **definitely know**, because they had a positive test result, was infected with COVID-19 **at the time** you were in contact with them? Yes No

If yes: (a) Date of last contact of this type:

D	D	M	M	M	2	0	2	Y
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(b) Was this last person you had this type of contact with living in your own home outside your home

2. In the last 28 days, have you been in direct contact, in person, with someone that you **think** 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? Yes No

If yes: (a) Date of last contact of this type:

D	D	M	M	M	2	0	2	Y
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(b) Was this last person you had this type of contact with living in your own home outside your home

3. In the last 28 days, have **you** been inside a hospital for any reason (e.g. for work, for a consultation or treatment, to visit someone, to take someone else)? Yes No

If no: (a) In the last 28 days, has **anyone that you usually live with** been inside a hospital at all for any reason (e.g. for work, for consultation or treatment, to visit someone, to take someone else)? Yes No

4. In the last 28 days, have **you** been inside a care/residential home for any reason (e.g. for work, to visit someone, to take someone else)? Yes No

If no: (a) In the last 28 days, has **anyone that you usually live with** been inside a care/residential home at all (e.g. for work, to visit someone, to take someone else)? Yes 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?

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6. Over the last 7 days, how many **children and young adults <18y** not living in your home have you had physical contact with (e.g. handshake, hug, personal care), including with PPE if you wear it? (*select one*)

0 1-5 6-10 11-20 21 or more

7. Over the last 7 days, how many adults 18-69y not living in your home have you had physical contact with (e.g. handshake, hug, personal care), including with PPE if you wear it? (*select one*)
 0 1-5 6-10 11-20 21 or more

8. Over the last 7 days, how many older adults 70y and over not living in your home have you had physical contact with (e.g. handshake, hug, personal care), including with PPE if you wear it? (*select one*)
 0 1-5 6-10 11-20 21 or more

9. Over the last 7 days, how many children and young adults <18y 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

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 generally wear any kind of face covering or mask when you are at work/your place of education, because of COVID-19? (*select one: if currently self-isolating, choose what you would usually do when not self-isolating*)
 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 generally 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: if currently self-isolating, choose what you would usually do when not self-isolating*)
 Not going to other enclosed public spaces or using public transport Never
 Yes, always Yes, sometimes

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) What was the earliest date when you knew or thought you first 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 (including high temperature) <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	More trouble sleeping than usual <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of appetite or eating less than usual <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
Sore throat <input type="checkbox"/> Yes <input type="checkbox"/> No	Runny nose/sneezing <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	Noisy breathing (wheezing) <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) <i>If all tests negative:</i> What was the date of last negative test you've had?	D	D	M	M	M	2	0	2	Y
3. <i>If yes to Q2:</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
4. Have you ever had a blood test to test for COVID-19 antibodies? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> (a) What was the result/were the results of all blood tests you've had? (<i>select one</i>) <input type="checkbox"/> One or more positive test(s) <input type="checkbox"/> One or more negative tests, but none were positive <input type="checkbox"/> All tests failed <input type="checkbox"/> Waiting for all results (b) Where was the test done? (<i>if more than one test, provide for the most recent positive test, otherwise the most recent negative test, otherwise the most recent test</i>) (<i>select one</i>) <input type="checkbox"/> In the NHS (e.g. GP, hospital) <input type="checkbox"/> Private lab <input type="checkbox"/> Home test									
(c) <i>If any tests positive:</i> What was the date of first positive test you've had?	D	D	M	M	M	2	0	2	Y
(d) <i>If all tests negative:</i> What was the date of last negative test you've had?	D	D	M	M	M	2	0	2	Y
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> (a) Does this reduce your ability to carry-out day-to-day activities compared with the time before you had COVID-19? (<i>select one</i>) <input type="checkbox"/> Yes, a lot <input type="checkbox"/> Yes, a little <input type="checkbox"/> Not at all (b) Have you had any of the following symptoms as part of your experience of long COVID? Please include any pre-existing symptoms which long COVID has made worse (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	Loss of appetite	<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	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	Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Vertigo/dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Worry/anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low mood/not enjoying anything	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Trouble sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory loss or confusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficultly concentrating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Have you ever been vaccinated against COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if no go to F7</i>) <i>If yes to Q6:</i> (b) how many doses of any vaccine have you received to date, including any booster doses? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more									
(c) What type of vaccination did you have for your first dose? (<i>select one</i>) <input type="checkbox"/> Don't know type <input type="checkbox"/> Pfizer/BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Oxford/AstraZeneca <input type="checkbox"/> Janssen\Johnson&Johnson <input type="checkbox"/> Sinopharm <input type="checkbox"/> Sinovac <input type="checkbox"/> Sputnik <input type="checkbox"/> Valneva <input type="checkbox"/> From a research study/trial <input type="checkbox"/> Other, specify _____									
(d) What was the date of your first vaccination? (<i>if you can't remember the day of the month, put the 15th</i>)	D	D	M	M	M	2	0	2	Y
(e) What type of vaccination did you have for your second dose? (<i>select one</i>) <input type="checkbox"/> Don't know type <input type="checkbox"/> Pfizer/BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Oxford/AstraZeneca <input type="checkbox"/> Janssen\Johnson&Johnson <input type="checkbox"/> Sinopharm <input type="checkbox"/> Sinovac <input type="checkbox"/> Sputnik <input type="checkbox"/> Valneva <input type="checkbox"/> From a research study/trial <input type="checkbox"/> Other, specify _____									
(f) What was the date of your second vaccination? (<i>if you can't remember the day of the month, put the 15th</i>)	D	D	M	M	M	2	0	2	Y
(g) What type of vaccination did you have for your third dose? (<i>select one</i>) <input type="checkbox"/> Don't know type <input type="checkbox"/> Pfizer/BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Oxford/AstraZeneca <input type="checkbox"/> Janssen\Johnson&Johnson <input type="checkbox"/> Sinopharm <input type="checkbox"/> Sinovac <input type="checkbox"/> Sputnik <input type="checkbox"/> Valneva <input type="checkbox"/> From a research study/trial <input type="checkbox"/> Other, specify _____									
(h) What was the date of your third vaccination? (<i>if you can't remember the day of the month, put the 15th</i>)	D	D	M	M	M	2	0	2	Y
(i) What type of vaccination did you have for your fourth dose? (<i>select one</i>) <input type="checkbox"/> Don't know type <input type="checkbox"/> Pfizer/BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Oxford/AstraZeneca <input type="checkbox"/> Janssen\Johnson&Johnson <input type="checkbox"/> Sinopharm <input type="checkbox"/> Sinovac <input type="checkbox"/> Sputnik <input type="checkbox"/> Valneva <input type="checkbox"/> From a research study/trial <input type="checkbox"/> Other, specify _____									

(j) What was the date of your fourth vaccination? (if you can't remember the day of the month, put the 15 th)	D	D	M	M	M	2	0	2	Y
7. Have you been vaccinated against flu since September 2021? (<i>this is commonly known as the 'flu jab' or 'seasonal flu vaccination'</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No									
8. Have you been outside of the UK since April 2020? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<i>If yes:</i> (a) Last country visited _____ (b) Date last returned to the UK									
D D M M M 2 0 2 Y									

G: CONTACT DETAILS FOR VOUCHERS AND RESULTS RETURN

1. Do you have an email address that we can use to contact you about the study, for example with updates and your vouchers? Please be aware that we would like to use this email to send you your test results, so it should not be a shared email address, except when children need to use their parents email address <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if no go to G2</i>)									
<i>If yes to Q1</i> (a) Email:									
(b) Repeat Email:									
(c) How would you prefer to receive vouchers for the study? <input type="checkbox"/> Email <input type="checkbox"/> Paper (by post)									
(d) Are you happy to receive your test results by email? <input type="checkbox"/> Yes <input type="checkbox"/> No									
2. Do you have a mobile number we can use to contact you (about this study only)? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<i>If yes:</i> (a) Mobile number (add country code if non-UK mobile):									

COMPLETED BY: Name (study worker)	Signature (study worker)	Date
		D D M M M 2 0 2 Y