Office for National Statistics

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 taken ☐Yes ☐No	If yes: barcode	If yes: shipment ID	
Blood taken ☐Yes ☐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)? ☐ Yes ☐ No
2. Did the participant consent to 5 visits (enrolment plus 4 follow-up) (Q6 on consent form)? ☐ Yes ☐ No
3. Did the participant consent to visits until end of the study (Q7 on consent form)? ☐ Yes ☐ No
4. Did the participant consent to be approached for other studies (Q8 on consent form)? ☐ Yes ☐ No
5. *If blood and swab household:* Is the participant 16y or older? ☐ Yes ☐ No
   If yes to Q5: (a) Did they consent to fingerprick samples (Q9 on consent form)? ☐ Yes ☐ No
   (b) *If yes*: did they consent to future use of blood samples (Q10 on consent form)? ☐ Yes ☐ No
6. *If swab ONLY household:* Is the participant 16y or older? ☐ Yes ☐ No
   If yes to Q6: (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)? ☐ Yes ☐ No
   (b) *If yes*: did they consent to future use of blood samples (Q10 on consent form)? ☐ Yes ☐ No

B: DEMOGRAPHICS

1. What is your sex? ☐ Male ☐ Female
2. What is your ethnic group? *(select one)*

White
☐ English, Welsh, Scottish, Northern Irish or British ☐ Irish ☐ Gypsy or Irish Traveller
☐ Any other white background, specify ____________________

Mixed / multiple ethnic groups
☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed/multiple background, specify: ____________________

Asian or Asian British
☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ Any other Asian background, specify:____________________

Black, African, Caribbean or Black British
☐ African ☐ Caribbean
☐ Any other Black, African or Caribbean background, specify: ____________________

Other ethnic group
☐ Arab
☐ 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? *(select one)*
   ☐ Employed and currently working (including if on leave or sick leave for less than 4 weeks) *(go to C3)*

☐ 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)*
☐ Self-employed and currently working (include if on leave or sick leave for less than 4 weeks) *(go to C3)*
☐ 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)*
☐ Looking for paid work and able to start *(go to Section D)*
☐ Not in paid work and not looking for paid work (include doing voluntary work here) *(go to Section D)*
☐ Retired (include doing voluntary work here) *(go to C2)*
☐ Child under 4-5y not attending nursery, pre-school, childminder *(go to Section D)*
☐ Child under 4-5y attending nursery, pre-school, childminder *(go to C8)*
☐ 4-5y and older at school/home-school (including if temporarily absent) *(go to C2 if 16y or older, otherwise C8)*
☐ Attending college or other further education provider (including apprenticeships) (including if temporarily absent) *(go to C2)*
☐ 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?
☐ Yes *(go to C3)* ☐ No *(go to C8 if 16y and older in education: go to Section D if Retired)*

3. *If currently working at all, or currently employed/self-employed but not working at the moment:*

(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)*
☐ Teaching and education
☐ Health care (*go to C4*)
☐ Social care (*go to C5*)
☐ Transport (incl. storage, logistic)
☐ Retail sector (incl. wholesale)
☐ Hospitality (e.g. hotel, restaurant, cafe)
☐ Food production and agriculture (incl. farming)
☐ Personal services (e.g. hairdressers, tattooists)
☐ Information technology and communication
☐ Financial services (incl. insurance)
☐ Manufacturing or construction
☐ Civil service or Local Government
☐ Armed forces
☐ Arts, entertainment or recreation
☐ Other employment sector, specify ________________________ *(go to C6 if not working in Health or Social care)*

4. *If 'Health care'*: Is that currently *(select one)* ☐ Primary care (e.g. GP, dentist) ☐ Secondary care (e.g. hospital) ☐ Other healthcare (e.g. mental health)

5. Do you currently work in a nursing care home or a residential care home? ☐ Yes ☐ 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) ☐ Yes ☐ No

7. *If currently working now (see C1, C2)*: Currently, do you generally work *(select one: if currently self-isolating, choose where you would usually work when not self-isolating)*
☐ From home (in the same grounds or building as your home) *(go to Section D)*
☐ Somewhere else (not at your home) *(go to C8)*
☐ Both (work from home and work somewhere else) *(go to C8)*

8. *If currently working not at your home, or in education or attending school/nursery, etc*: 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)*
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

9. *If currently working not at your home, or in education or attending school or nursery, etc*: 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)
☐ Underground, metro, light rail, tram ☐ Train ☐ Bus, minibus, coach ☐ Motorbike, scooter or moped
☐ Car or van ☐ Taxi/minicab ☐ Bicycle ☐ On foot ☐ Other method

10. *If currently working or in education or attending school or nursery, etc*: 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)*
☐Easy to maintain 2m, it is not a problem to stay this far away from other people
☐Relatively easy to maintain 2m, most of the time you can be 2m away from other people
☐Difficult to maintain 2m, but you can usually be at least 1m from other people
☐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**?

Symptom			Symptom			Symptom		
Fever (including high temperature)	☐ Yes	☐ No	Headache	☐ Yes	☐ No	Muscle ache	☐ Yes	☐ No
Weakness/tiredness	☐ Yes	☐ No	More trouble sleeping than usual	☐ Yes	☐ No	Loss of appetite or eating less than usual	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No	Diarrhoea	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No	Runny nose/sneezing	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Noisy breathing (wheezing)	☐ Yes	☐ No	Loss of taste	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No	Palpitations	☐ Yes	☐ No
Vertigo/dizziness	☐ Yes	☐ No	Worry/anxiety	☐ Yes	☐ No	Low mood/not enjoying anything	☐ Yes	☐ No
Memory loss or confusion	☐ Yes	☐ No	Difficulty concentrating	☐ Yes	☐ 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

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/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

   (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

   (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? ☐☐

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
☐ 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) What was the earliest date when you knew or thought you first had COVID-19: D D M M M 2 0 2 Y

(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)

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Fever (including high temperature)	☐ Yes	☐ No	Headache	☐ Yes	☐ No	Muscle ache	☐ Yes	☐ No
Weakness/tiredness	☐ Yes	☐ No	More trouble sleeping than usual	☐ Yes	☐ No	Loss of appetite or eating less than usual	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No	Diarrhoea		
Sore throat	☐ Yes	☐ No	Runny nose/ sneezing	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Noisy breathing (wheezing)	☐ Yes	☐ No	Loss of taste	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No	Palpitations	☐ Yes	☐ No
Vertigo/dizziness	☐ Yes	☐ No	Worry/anxiety	☐ Yes	☐ No	Low mood/not enjoying anything	☐ Yes	☐ No

Memory loss or confusion ☐ Yes ☐ No	Difficulty concentrating ☐ Yes ☐ 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
(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

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)* *(select one)*

☐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
(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

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

If yes: (a) Does this reduce your ability to carry-out day-to-day activities compared with the time before you had COVID-19? *(select one)* ☐ Yes, a lot ☐Yes, a little ☐ 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 (including high temperature)	☐ Yes ☐ No	Headache	☐ Yes ☐ No	Muscle ache	☐ Yes ☐ No
Weakness/tiredness	☐ Yes ☐ No	Nausea/vomiting	☐ Yes ☐ No	Abdominal pain	☐ Yes ☐ No
Diarrhoea	☐ Yes ☐ No	Loss of appetite or eating less than usual	☐ Yes ☐ No	Loss of taste	☐ Yes ☐ No
Loss of smell	☐ Yes ☐ No	Sore throat	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No	Palpitations	☐ Yes ☐ No
Vertigo/dizziness	☐ Yes ☐ No	Worry/anxiety	☐ Yes ☐ No	Low mood/not enjoying anything	☐ Yes ☐ No
More trouble sleeping than usual	☐ Yes ☐ No	Memory loss or confusion	☐ Yes ☐ No	Difficulty concentrating	☐ Yes ☐ No
Runny nose/ sneezing	☐ Yes ☐ No	Noisy breathing (wheezing)	☐ Yes ☐ No		

6. Have you ever been vaccinated against COVID-19? ☐ Yes ☐ No *(if no go to F7)*

If yes to Q6: (b) how many doses of any vaccine have you received to date, including any booster doses?
☐ 1 ☐ 2 ☐ 3 or more

(c) What type of vaccination did you have for your first dose? *(select one)* ☐ Don't know type

☐ Pfizer/BioNTech ☐ Moderna
☐ Oxford/AstraZeneca ☐ Janssen\Johnson&Johnson ☐ Novavax
☐ Sinovac ☐ Sputnik ☐ Valneva ☐ Sinopharm
☐ From a research study/trial ☐ Other, specify______________________

(d) What was the date of your first vaccination? *(if you can't remember the day of the month, put the 15th)*	D	D	M	M	M	2	0	2	Y

(e) What type of vaccination did you have for your second dose? *(select one)* ☐ Don't know type

☐ Pfizer/BioNTech ☐ Moderna
☐ Oxford/AstraZeneca ☐ Janssen\Johnson&Johnson ☐ Novavax
☐ Sinovac ☐ Sputnik ☐ Valneva ☐ Sinopharm
☐ From a research study/trial ☐ Other, specify______________________

(f) What was the date of your second vaccination? *(if you can't remember the day of the month, put the 15th)*	D D M M M 2 0 2 Y
(g) What type of vaccination did you have for your third dose? *(select one)* ☐ Don't know type ☐ Pfizer/BioNTech ☐ Moderna ☐ Oxford/AstraZeneca ☐ Janssen\Johnson&Johnson ☐ Novavax ☐ Sinovac ☐ Sputnik ☐ Valneva ☐ Sinopharm ☐ From a research study/trial ☐ Other, specify______________________	
(h) What was the date of your third vaccination? *(if you can't remember the day of the month, put the 15th)*	D D M M M 2 0 2 Y
(i) What type of vaccination did you have for your fourth dose? *(select one)* ☐ Don't know type ☐ Pfizer/BioNTech ☐ Moderna ☐ Oxford/AstraZeneca ☐ Janssen\Johnson&Johnson ☐ Novavax ☐ Sinovac ☐ Sputnik ☐ Valneva ☐ Sinopharm ☐ From a research study/trial ☐ Other, specify______________________	
(j) What was the date of your fourth vaccination? *(if you can't remember the day of the month, put the 15th)*	D D M M M 2 0 2 Y
7. Have you been vaccinated against flu since September 2021? *(this is commonly known as the 'flu jab' or 'seasonal flu vaccination')* ☐ Yes ☐ No	
8. Have you been outside of the UK since April 2020? ☐ Yes ☐ No	
If yes: (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
☐ Yes ☐ No *(if no go to G2)*

If yes to Q1 (a) Email: ....

(b) Repeat Email:……………………………………………………………………………………………

(c) How would you prefer to receive vouchers for the study? ☐ Email ☐ Paper (by post)

(d) Are you happy to receive your test results by email? ☐ Yes ☐ No

2. Do you have a mobile number we can use to contact you (about this study only)? ☐ Yes ☐ No

If yes: (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