COVID-19 INFECTION SURVEY: CRF5 INDIVIDUAL PARTICIPANT – COMPLETE AT EACH FOLLOW-UP VISIT (NOT AT ENROLMENT)

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 parti-cipant 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: 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 A3)*
   - ☐ 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 A3)*
   - ☐ Self-employed and currently working (include if on leave or sick leave for less than 4 weeks) *(go to A3)*
   - ☐ 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 A3)*
   - ☐ Looking for paid work and able to start *(go to Section B)*
   - ☐ Not in paid work and not looking for paid work (include doing voluntary work here) *(go to Section B)*
   - ☐ Retired (include doing voluntary work here) *(go to A2)*
   - ☐ Child under 4-5y not attending nursery, pre-school, childminder *(go to Section B)*
   - ☐ Child under 4-5y attending nursery, pre-school, childminder *(go to A8)*
   - ☐ 4-5y and older at school/home-school (including if temporarily absent) *(go to A2 if 16y or older, otherwise A8)*
   - ☐ Attending college or other further education provider (including apprenticeships) (including if temporarily absent) *(go to A2)*
   - ☐ Attending university (including if temporarily absent) *(go to A2)*

2. Do you have any paid employment in addition to this, or as part of an apprenticeship?
   ☐ Yes *(go to A3)* ☐ No *(go to A8 if 16y and older in education: go to Section B if Retired)*

3. *If currently working at all*: Has your main job/business changed since we last spoke to you? ☐ Yes ☐ No
   If no, and not currently working, go to Section B. Otherwise, go to A6.
   If yes: (a) What is your job title in your main job/business now?____________________
   (b) And in this job/business, what do you mainly do now?____________________
   (c) Which of these employment sectors do you work in now? *(select one)*
   - ☐ Teaching and education
   - ☐ Social care *(go to A5)*
   - ☐ Retail sector (incl. wholesale)
   - ☐ Food production and agriculture (incl. farming)
   - ☐ Information technology and communication
   - ☐ Manufacturing or construction
   - ☐ Armed forces
   - ☐ Other employment sector, specify ______________
   - ☐ Health care *(go to A4)*
   - ☐ Transport (incl. storage, logistic)
   - ☐ Hospitality (e.g. hotel, restaurant, cafe)
   - ☐ Personal services (e.g. hairdressers, tattooists)
   - ☐ Financial services (incl. insurance)
   - ☐ Civil service or Local Government
   - ☐ Arts, entertainment or recreation

   (go to A6 if not now working in Health or Social care)

4. *If now working in 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. *If currently working now (see A1, A2):* 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 A1, A2)*: 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 B)*
   - ☐ Somewhere else (not at your home) *(go to A8)*
   - ☐ Both (work from home and work somewhere else) *(go to A8)*

8. *If currently working not at your home, or in education or attending school or 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

B: 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

C: 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)*
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)

D: COVID-19 INFECTION AND YOU

1. Do you know or think you have had coronavirus (COVID-19) since we last spoke to you? (*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 knew or thought you had COVID-19? ☐ Yes ☐ No

(c) *If yes:* Did you have any of the following symptoms? (answer Yes or No for each one)

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			

(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 had a swab test of your nose and throat to test for COVID-19 since we last spoke to you (not including any tests done as part of this study)? ☐ Yes ☐ No

If yes: (a) What was the result/were the results of all tests you've had since we last spoke to you? *(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 since we last spoke to you? 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 since we last spoke to you? 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 about 30 minutes?
☐ Yes ☐ No

4. Have you had a blood test to test for COVID-19 antibodies since we last spoke to you (not including any tests done as part of this study)? ☐ Yes ☐ No

If yes: (a) What was the result/were the results of all tests you've had since we last spoke to you? *(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 test positive:* What was the date of first positive test you've had since we last spoke to you? 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 since we last spoke to you? D D M M M 2 0 2 Y

5. *If week 4 or later*: 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) Do you have 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)

Symptom			Symptom			Symptom		
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 been vaccinated against COVID-19 since we last spoke to you? (Still *select Yes if you have received a second or later dose, or a booster dose since we last spoke to you*) ☐ Yes ☐ No (if no go to D7)

If yes to Q6: (b) Type of vaccination (*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______________________

(c) Number of doses received to date ☐ 1 ☐ 2 ☐ 3 or more

(d) Date of most recent vaccination 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 we last spoke to you? ☐ Yes ☐ No

If yes: (a) Last country visited ____________________________ (b) Date last returned to the UK D D M M M 2 0 2 Y

E: ADDITIONAL CONSENT – Do not take additional consent if database is unavailable

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