

**COVID-19 INFECTION SURVEY: CRF2 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 household code																			Participant date of birth	D	D	M	M	M	Y	Y	Y	Y									
Unique participant code																			Date/time of visit	D	D	M	M	M	2	0	2	Y	h	h	:	m	m				
Swab taken <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: barcode																		If yes: shipment ID																		
Blood taken <input type="checkbox"/> Yes <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	Type of visit <input type="checkbox"/> Contact <input type="checkbox"/> Non-contact																						

A: WORK, SCHOOL AND NURSERY

- 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)*
- 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)*
- If currently working at all:*** Has your main job/business changed since we last spoke to you? Yes No
If no, go to A7.
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 _____ *(go to A6 if not now working in Health or Social care)*
 - 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
- 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)
- Do you currently work in a nursing care home or a residential care home? Yes No
- 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
- If currently working now (see A1, A2):*** Currently, do you work? *(select one)*
 - 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*) 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?

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

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

(b) If yes: date first symptom onset:

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

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
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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

<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?		<input type="text"/>	<input type="text"/>
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, but not physical, 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 <u>adults 18-69y</u> not living in your home have you had direct, but not physical, 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
11. Over the last 7 days, how many older <u>adults 70y</u> and over not living in your home have you had direct, but not physical, 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
12. In the last 7 days, how many times have you spent one hour or longer inside the buildings of another person's home? (<i>select one</i>)		<input type="checkbox"/> None	<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 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? (<i>select one</i>)		<input type="checkbox"/> None	<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 times or more
14. In the last 7 days, how many times have you been outside of your home for shopping or socialising (including visiting restaurants etc)? (<i>select one</i>)		<input type="checkbox"/> None	<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 times or more
15. Do you wear any kind of face covering or mask when you are at work/your place of education, because of COVID-19? (<i>select one</i>)		<input type="checkbox"/> Not going to place of work or education <input type="checkbox"/> Yes, always <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Never <input type="checkbox"/> My face is already covered for other reasons (e.g. religious or cultural reasons)	
16. 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? (<i>select one</i>)		<input type="checkbox"/> Not going to other enclosed public spaces or using public transport <input type="checkbox"/> Yes, always <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Never <input type="checkbox"/> 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? (<i>if not sure, select No</i>)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes:</i> (a) On what date did you first know or think you had COVID-19:		<input type="text"/>	<input type="text"/>
(b) Did you have any symptoms when you knew or thought you had COVID-19?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) <i>If yes:</i> Did you have any of the following symptoms? (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
Weakness/tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/vomiting	<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
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of taste	<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)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(e) Were you admitted to hospital when you thought you had COVID-19?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes:</i> (a) What was the result/were the results of all tests you've had since we last spoke to you? (<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) <i>If any test positive:</i> What was the date of first positive test you've had since we last spoke to you?		<input type="text"/>	<input type="text"/>

<i>(c) If all tests negative:</i> 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. 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> (a) What was the result/were the results of all tests you've had since we last spoke to you? (<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, (select one) otherwise the most recent negative test, otherwise the most recent test</i>) <input type="checkbox"/> In the NHS (e.g. GP, hospital) <input type="checkbox"/> Private lab <input type="checkbox"/> Home test									
<i>(c) If any test positive:</i> 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
<i>(d) If all tests negative:</i> 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
4. <i>If week 4 or later:</i> 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) 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)									
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	Difficulty concentrating <input type="checkbox"/> Yes <input type="checkbox"/> No							
5. Have you been vaccinated against COVID-19 since we last spoke to you? (<i>select Yes if you have received a second or later dose since we last spoke to you</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No									
<i>If yes:</i> (a) Type of vaccination (<i>select one</i>) <input type="checkbox"/> Don't know type <input type="checkbox"/> Pfizer/BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Oxford/AstraZeneca <input type="checkbox"/> From a research study/trial <input type="checkbox"/> Other, specify _____									
(b) Number of doses received to date <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more									
(c) Date of most recent vaccination									
D	D	M	M	M	2	0	2	Y	
6. Have you been outside of the UK since we last spoke to you? <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	
COMPLETED BY: Name (study worker)			Signature (study worker)			Date			
D	D	M	M	M	2	0	2	Y	