COVID-19 QUESTIONNAIRE

Thank you for completing this questionnaire! As the recent COVID-19 pandemic continues to affect all of our lives, we are seeking your help to better understand how COVID-19 has affected your current health and lifestyle.

You will have **SIX WEEKS** to complete this questionnaire. You do not need to finish this questionnaire all at once. You may pause, save your progress and return to it at a later time. To regain access, please go back to the email invitation and follow the link provided.

This questionnaire is designed to assess the impact that COVID-19 may have had on your health, both physical and mental, to ask about the known risk factors for COVID-19, and to learn about how the pandemic affected other parts of your life, such as your social support network and employment status.

Even if you have NOT experienced COVID-19 symptoms or have been diagnosed with COVID-19, please take the questionnaire as your answers are still valuable to health researchers.

Please avoid using your browser's back button. Forward and back buttons have been provided within the questionnaire.

Before starting this questionnaire, please gather a tape measure and a bathroom scale as we will be asking you for some body measurements at the end.

DEMOGRAPHIC INFORMATION

DE01. How old are you?
_____ years

DE02. What was your sex at birth?
Male
Female

The next few questions ask about sex and gender. Both biological and social differences between women and men contribute to differences in their health. Sex (biological attributes) and gender (socio-cultural factors) can influence things like our risk of developing certain diseases, response to medical treatments, and how often we seek health care.

DE03. Which best describes your current gender identity?
Male
Female
Indigenous or other cultural gender minority (e.g., two-spirit)
Other (e.g., gender fluid, non-binary)
Prefer not to answer

DE04. What gender do you currently live as in your day-to-day life?
Male
Female
Sometimes male, sometimes female
Something other than male or female
Prefer not to answer

DE05. Are you currently pregnant?
Yes
No
Don't know

DE06. [IF YES] In what week are you?
_____weeks

DE07. How many adults (age 18 or older) and children (under 18 years of age) <u>including yourself</u> are currently living in your household?
I live alone
Number of children under 18 years old? ___
Number of adults 18 to 59 years old? ___
Number of adults 60 to 69 years old? ___
Number of adults 70 to 79 years old? ___
Number of adults 80 years old or more? ___
Don't know

DE08. What type of dwelling do you currently live in?
House (e.g., single detached, semi-detached, duplex or townhouse)
Apartment or condominium
Seniors' housing (e.g., retirement home, senior lodges, senior residences, assisted living)
Institution (e.g., long-term care facility, nursing home)
Other (e.g. mobile home, hotel, rooming house, or group home)
Don't know
Prefer not to answer

DE09. What is your current residential Postal Code? *Please enter in the format A1A2A2 with no spaces.*
Postal Code:_____
I live outside of Canada
Prefer not to answer
Don't know

COVID-19 DIAGNOSES

DG01. Have you used an online screening or self-assessment tool to determine if you might have and/or should be tested for COVID-19?
Yes
No
Prefer not to answer

DG02. [IF YES] What was the source of the self-assessment tool? (Select all that apply)
Provincial health authority or government
Employer
Other
Don't know

DG03. As of today, have you been tested for COVID-19?
Yes
No – because I haven't experienced any symptoms
No – I have experienced one or more symptoms (for example, a cough, mild fever, muscle soreness, fatigue) but have not been tested
No – I have experienced symptoms but I do/did not meet the testing criteria in my province
Prefer not to answer

DG04. [IF DG03=Yes] What was the result of your COVID-19 test?
Negative
Positive
Prefer not to answer
Don't know or have not received results yet

DG05. [IF DG03=Yes]What was the date of your COVID-19 test?
Value (DD-MM-YYYY)
Prefer not to answer
Don't know

DG06. What was the date that you received the results?
Value (DD-MM-YYYY)
Prefer not to answer
Don't know

DG07. [IF DG03=Yes or No – I have experienced symptoms but I do/did not meet the testing criteria in my province] Do you suspect you have/had an undiagnosed case of COVID-19?
Yes
No
Don't know

DG08. Did you receive treatment with any experimental therapies for COVID-19 for prevention or treatment?
Yes
No
Prefer not to answer
Don't know

DG09. [IF YES] Which experimental therapies did you receive? Select all that apply.
Remdesivir
Chloroquine/Hydroxychloroquine
Lopinavir-Ritonavir
Tocilizumab
Colchicine
Other – please specify:_____
Prefer not to answer
Don't know

DG10. [IF DG08 = YES] Were the therapies described above prescribed to you by a clinician for COVID-19?
Yes
No
Prefer not to answer
Don't know

COVID-19 SYMPTOMS

We are interested in whether you've experienced flu-like and other symptoms, which may be related to COVID-19. For these next questions, please consider any symptoms which are not due to other health issues you might usually experience/expect, such as seasonal allergies, existing medical conditions, etc.

SY01. Have you had a fever since January 1, 2020?
Yes
No
Don't know

SY02. [IF YES] How long did it last (if you had more than one fever answer this question for the longest period)?
Hours:_____
Or Days:_____
Don't know

SY03. What was the highest temperature recorded?

_____°C
_____°F
I did not take my temperature
Don't know

SY04. Since January 1, 2020, have you experienced any of the following symptoms? Please do not include symptoms related to factors you might usually experience/expect, such as seasonal allergies, asthma, COPD, or other existing medical conditions.

	No	Mild	Severe	Don't know
Dry cough				
Wet cough (cough that produces mucus)				
Runny nose				
Sinus pain				
Ear pain				
Sore throat				
Hoarseness				
Shortness of breath or difficulty breathing				
Headache				
Fatigue				
General muscle and/or joint aches and pains				
Chills or shivering				
Loss of taste				
Loss of sense of smell				
Diarrhea				
Loss of appetite				
Nausea				
Vomiting				

Did you experience any other symptoms?
Yes – please specify:_____
No other symptoms

[IF YES] How severe were these symptoms?

Mild
Severe
Don't know

SY05. [IF YES TO ANY SYMPTOMS] When did you first experience these symptoms?
If you don't remember the exact date, please provide the best estimate that you can.
Value (DD-MM-YYYY)
Don't know

SY06. [IF YES TO ANY SYMPTOMS] Do you feel back to normal?
Completely
Mostly
A bit
Not really
Not at all

SY07. [IF YES to Completely or Mostly] If you feel back to normal, how long were you sick for?
Number of days:_____
Don't know

SY08.

	No	Mild	Severe	Don't know
Do you still have difficulty with a fever?				
Do you still have difficulty with a dry cough?				
Do you still have difficulty with a wet cough (cough that produces mucus)?				
Do you still have difficulty with a runny nose?				
Do you still have difficulty with sinus pain?				
Do you still have difficulty with ear pain?				

	No	Mild	Severe	Don't know
Do you still have difficulty with a sore throat?				
Do you still have difficulty with hoarseness?				
Do you still have difficulty with shortness of breath or difficulty breathing?				
Do you still have difficulty with headaches?				
Do you still have difficulty with fatigue?				
Do you still have difficulty with general muscle and/or joint aches and pains?				
Do you still have difficulty with chills or shivering?				
Do you still have difficulty with loss of taste?				
Do you still have difficulty with loss of sense of smell?				
Do you still have difficulty with diarrhea?				
Do you still have difficulty with loss of appetite?				
Do you still have difficulty with nausea?				
Do you still have difficulty with vomiting?				

SY09. [IF YES TO ANY SYMPTOMS] While you were experiencing COVID-19 related symptoms, did you have close contact with any of the following? Close contact means physical contact such as hugging, kissing, shaking hands, etc.

	Yes	No	Don't know
Spouse or partner			
Family members living in the same place			
Family members living in another place			
Housemates			
Friends			
Work colleagues			

SY10. [IF YES] Have any of those person(s) developed COVID-related symptoms?
Yes
No
Don't know

SY11. [IF YES] For those person(s) that developed COVID-related symptoms, which category/categories did they belong to and how many individuals were affected? Select all that apply
Spouse or partner
Family members living in the same place - number of individuals:_____
Family members living in another place - number of individuals:_____
Housemates - number of individuals:_____
Friends - number of individuals:_____
Work colleagues - number of individuals:_____

COVID-19 - CARE/HOSPITAL RELATED INFORMATION

The following questions are only presented to participants with a positive test result for Covid-19.

CH01. Were you hospitalized because of COVID-19?
Yes
No
Don't know

CH02. [IF YES] What date did you get admitted to the hospital?
DD-MM-YYYY
Don't know

CH03. [IF YES] How many days were you in the hospital?

Number of days
Don't know

CH04. Were you admitted to an intensive care unit?
Yes
No
Don’t know

CH05. [IF YES] How long did you stay in the intensive care unit?
Number of days:_____
Don’t know

CH06. Did you have a chest X-ray or CT scan?
Yes
No
Don’t know

CH07. Did you require mechanical ventilation for COVID-19?
Yes
No
Don’t know

CH08. [IF YES] How many days did you receive mechanical ventilation?
Number of days:_____
Don’t know

CH09. What was the reason for ending hospitalization?
Discharge (recovered)
Other/Unknown

CH10. Have you experienced complications related to hospitalization after you were discharged?
Yes
No
Don’t know

CH11. [IF YES] Did you require further treatment or hospitalization?
Yes
No
Don’t know

<u>COVID-19 – EXPOSURE</u>

EX01. Did you travel after January 1, 2020 (including within and outside your province)?

Yes
No
Don't know

EX02. [IF YES] If you travelled after January 1, 2020 how far did you travel? (Check all that apply in the questions that follow - if you had multiple trips, please list details for your most recent trip for domestic and/or international travel, if applicable).

Domestic (within province)
Domestic (outside of province but within Canada)
[IF YES] What city did you travel to for your most recent trip?
_____
What were your dates of travel for your most recent trip? ***Note: The date entered must be later than or the same as the travel start date.***
From DD MM YYYY
To DD MM YYYY
Don't know
International
[IF YES] What countries did you travel to for your most recent trip? _____
What were your dates of travel for your most recent trip? ***Note: The date entered must be later than or the same as the travel start date.***
From DD MM YYYY
To DD MM YYYY
Don't know
Travel on a cruise ship
[IF YES] What were your dates of travel? ***Note: The date entered must be later than or the same as the travel start date.***
From DD MM YYYY
To DD MM YYYY
Don't know

EX03. We're interested in whether other people may have exposed you to COVID-19. To your knowledge, have you been in the same room as a person who was told by a physician that they have COVID-19?
Yes
No
Don't Know

EX04. [IF YES] On which date did you have first contact with this person after they were diagnosed with COVID-19?
If you don't remember the exact date, please provide the best estimate that you can.
DD MM YYYY
Don't know

EX05. [If EX03=Yes] Who was this person with COVID-19?
Spouse or partner
Family member living in the same place
Family member living in another place
Housemate
Friend
Work colleague
Other – please specify

EX06. To your knowledge, since January 1, 2020 have you been in the same room as a person who went on to develop symptoms of COVID-19? These include fever, severe fatigue, shortness of breath, dry cough, muscle pain or increased phlegm production.
Yes
No
Don't Know

EX07. [IF YES] On which date did you have first contact with this person before they started experiencing symptoms of COVID-19?
DD MM YYYY
Don't know

EX08. [IF YES] Who was this person with symptoms of COVID-19?
Spouse or partner
Family member living in the same place
Family member living in another place
Housemate
Friend
Work colleague
Other – please specify

EX09. To your knowledge, have you been in the same room as someone who returned from an international trip after January 1, 2020? If you have travelled internationally since January 1, 2020, do not include people that you travelled with.
Yes
No
Don't Know

EX10. [IF YES] On which date did you have first contact with this person after they returned from their trip?
If you don't remember the exact date, please provide the best estimate that you can.
DD MM YYYY
Don't know

EX011. Have you been in any large public gatherings of greater than 250 people (such as a concert) since January 1 2020?
Yes
No
Don't know

The provinces declared COVID-19 a public health emergency in March 2020, and put recommended prevention measures in place, including restrictions on activities outside the home, physical distancing, and public gatherings to reduce the risk of exposure to COVID-19.

EX12. Since March 2020, which of the following measures did you undertake? (Select all that apply, even if there are some that you no longer practice due to changing public health guidelines.)
Worked from home, where that was an option for your job
Stocked up on essentials at a grocery store or pharmacy
Avoided leaving the house for non-essential reasons
Used social distancing when out in public (i.e. made changes in your everyday routine to minimize close contact with others)
Avoided crowds and large gatherings
Did not visit with people outside my household
Wore a mask when going out in public
Wore gloves when going out in public
Washed your hands more regularly
Avoided touching your face
Cancelled travel
Other – please specify:_____
None

EX13. Did you regularly take public transit before March 2020?
Yes
No
Prefer not to answer
Don't Know

EX 14. [IF YES] Have you changed how frequently you take public transit since the province declared a public health emergency?
Yes – I have stopped taking public transit
Yes – I take public transit less frequently
No
Prefer not to answer
Don't know

For the next two questions, please use the following definitions:
Self-isolation*: no symptoms or positive test, but stayed at home other than essential errands or exercise, including working from home where that was possible.*
Quarantine*: did not leave your house or yard due to recent travel, symptoms, positive test, or possible exposure to someone diagnosed with COVID-19.*

EX15. To date, have you self-isolated during the COVID-19 pandemic?
Yes
No
Prefer not to answer
Don't know

EX16. [IF YES] How long were you in self-isolation?
Number of weeks:_____
Don't know

EX17. [IF YES to the parent question] How many people (adults and children) living in your home were in self-isolation with you?
Number of people:_____
Don't know

EX18. [IF YES to the parent question] Are you still in self-isolation?
Yes
No
Prefer not to answer
Don't know

EX19. To date, have you or anyone in your household been in quarantine during the COVID-19 pandemic?
Yes
No
Prefer not to answer
Don't know

EX20. [IF YES] If you or anyone in your household is still in quarantine, how long has it been?
Number of days:_____
Members of my household are no longer in quarantine
Don't know

EX21. If you or anyone in your household has completed quarantine, how long has it been since quarantine was completed?
Number of weeks:_____
Quarantine is ongoing

9 Don’t know

EX22. [IF YES] Did/Do you have someone to help meet your immediate needs (e.g. food, medicine, etc.)?
Yes
No
Don’t know

EX23. Are you working as a medical professional (physician, nurse, hospital employee, first responder, pharmacist) with exposure to patients?
Yes
No
Prefer not to answer
Don't know

EX24. Are you working as an essential service provider (grocery store attendant, public transit, police, security, etc.) with regular exposure to members of the public?
Yes
No
Prefer not to answer
Don’t know

EX25. Below are a series of statements about COVID-19; please indicate the degree to which you agree or disagree with the statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
COVID-19 poses a major threat to the public					
I think the situation with COVID-19 is overblown					
Because of my location, profession, and/or lifestyle, I am personally at a high risk of contracting COVID-19					
Because of my age and/or pre-existing conditions, I am likely to have serious symptoms if I were to contract COVID-19					
Because of my age and/or pre-existing conditions, I am likely to need hospitalization					

if I were to contract COVID-19					
The seasonal flu is just as dangerous as COVID-19					
COVID-19 was created in a lab on purpose					

RISK FACTORS

As the COVID-19 virus affects the respiratory system, the next few questions ask about smoking cigarettes, e-cigarettes and cannabis.

RF01. At the present time, do you smoke cigarettes daily, occasionally, or not at all?
Daily (At least one cigarette every day for the past 30 days)
Occasionally (At least one cigarette in the past 30 days, but not every day)
Not at all (You did not smoke at all in the past 30 days)

RF02. [IF YES to Daily or Occasionally] Has your smoking changed since March 2020?
No
Yes – smoking more than before
Yes – smoking less than before
Don't know

RF03. Have you ever tried an electronic cigarette, also known as an e-cigarette?
Vaping products have many names, such as: e-cigarettes, vape pens, vapes, mods, tanks, and e-hookahs. They may also be known by various brand names.
Yes
No
Don't know

RF04. [IF YES] In the past 30 days did you use an e-cigarette?
Yes
No
Don't know

RF05. Has your use of e-cigarettes changed since March 2020?
No
Yes – using more than before
Yes – using less than before
Don't know

RF06. Have you used cannabis in the past 12 months?
Yes
No

Prefer not to answer
Don’t know

RF07. [IF YES] In the past 12 months, have you used cannabis for any of the following?
Non-medical purposes only
Medical purposes only, either with or without a medical document
Both medical and non-medical purposes
Prefer not to answer
Don’t know

RF08. In the past 12 months, which of the following methods to consume cannabis did you use most often?
Smoked
Vaporized
Consumed in food or drink
Other
Prefer not to answer
Don’t know

RF09. Has your use of cannabis changed since March 2020?
No
Yes – using more often than before
Yes – using less often than before
Don’t know

RF10. On average, over the last year, how often did you drink alcohol?
6 to 7 times a week
4 to 5 times a week
2 to 3 times a week
Once a week
2 to 3 times a month
About once a month
Less than once a month
Never
Don't know

RF11. [IF RF10=any option other than Never or Don’t know) Has your alcohol consumption changed since March 2020?
No
Yes – drinking alcohol more often than before
Yes – drinking alcohol less often than before
Don’t know

MEDICAL CONDITIONS

COVID-19 is a new disease and evidence of risk factors continues to evolve. People who have pre-existing medical conditions, or who have compromised immune systems may be at higher risk of serious illness, similar to what is seen with other respiratory illnesses, such as influenza.

MC01. Has a doctor ever told you that you had a cancer or a malignancy of any kind?

Yes, select all that apply
No
Don't know

MC02.

Breast	Are you currently undergoing treatment for breast cancer? Yes No Don't know
Colon	Are you currently undergoing treatment for colon cancer? Yes No Don't know
Leukemia	Are you currently undergoing treatment for leukemia? Yes No Don't know
Lung and bronchus	Are you currently undergoing treatment for lung and bronchus cancer? Yes No Don't know
Lymphoma (Hodgkin Lymphoma)	Are you currently undergoing treatment for lymphoma (Hodgkin lymphoma) cancer? Yes No Don't know
Lymphoma (non-Hodgkin Lymphoma)	Are you currently undergoing treatment for lymphoma (Non-Hodgkin lymphoma) cancer? Yes No

	Don’t know
Pancreatic	Are you currently undergoing treatment for pancreatic cancer? Yes No Don’t know
Prostate	Are you currently undergoing treatment for prostate cancer? Yes No Don’t know
Rectum	Are you currently undergoing treatment for rectal cancer? Yes No Don’t know
Skin (Melanoma)	Are you currently undergoing treatment for skin (melanoma) cancer? Yes No Don’t know
Skin (Non-Melanoma)	Are you currently undergoing treatment for skin (non-melanoma) cancer? Yes No Don’t know
Thyroid	Are you currently undergoing treatment for thyroid cancer? Yes No Don’t know
Uterus	Are you currently undergoing treatment for uterine cancer? Yes No Don’t know
Other cancer or malignancy – please specify: _____	Are you currently undergoing treatment for the other cancer or malignancy specified? Yes No Don’t know

MC03. Has a doctor ever told you that you had any of the following conditions?

Condition	Diagnosed	Are you currently being treated?
Diabetes	Yes No Don't know If yes, which type of diabetes was it?	
	Type 1 diabetes	[IF SELECTED] Are you currently being treated for Type 1 diabetes? Yes No Don't know
	Type 2 diabetes	[IF SELECTED] Are you currently being treated for Type 2 diabetes? Yes No Don't know
	Gestational diabetes only	[IF SELECTED] Are you currently being treated for gestational diabetes? Yes No Don't know
Heart and circulatory conditions	Yes, select all that apply No Don't know	
	High blood pressure (hypertension, not including during pregnancy)	[IF SELECTED] Are you currently being treated for high blood pressure (hypertension, not including during pregnancy)? Yes No Don't know
	Heart attack (myocardial infarction)	[IF SELECTED] Are you currently being treated for a

Condition	Diagnosed	Are you currently being treated?
		heart attack (myocardial infarction)? Yes No Don't know
	Heart failure	[IF SELECTED] Are you currently being treated for heart failure? Yes No Don't know
	Atherosclerosis / Coronary heart disease (including angioplasty or stents)	[IF SELECTED] Are you currently being treated for atherosclerosis / coronary heart disease (including angioplasty or stents)? Yes No Don't know
	Atrial fibrillation	[IF SELECTED] Are you currently being treated for atrial fibrillation? Yes No Don't know
	Angina	[IF SELECTED] Are you currently being treated for angina? Yes No Don't know
	Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)	[IF SELECTED] Are you currently being treated for valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)? Yes No Don't know
Respiratory system conditions	Yes, select all that apply No	

Condition	Diagnosed	Are you currently being treated?
	Don’t know	
	Asthma	[IF SELECTED] Are you currently being treated for asthma? Yes No Don’t know
	Chronic obstructive pulmonary disease (COPD)	[IF SELECTED] Are you currently being treated for chronic obstructive pulmonary disease (COPD)? Yes No Don’t know
	Interstitial lung disease (lung tissue scarring resulting from other health conditions or exposures)	[IF SELECTED] Are you currently being treated for interstitial lung disease? Yes No Don’t know
	Chronic bronchitis	[IF SELECTED] Are you currently being treated for chronic bronchitis? Yes No Don’t know
	Cystic fibrosis	[IF SELECTED] Are you currently being treated for cystic fibrosis? Yes No Don’t know
	Emphysema	[IF SELECTED] Are you currently being treated for emphysema? Yes No Don’t know

Condition	Diagnosed	Are you currently being treated?
	Sleep apnea	[IF SELECTED] Are you currently being treated for sleep apnea? Yes No Don't know
Gastrointestinal conditions	Yes, select all that apply No Don't know	
	Crohn's disease	[IF SELECTED] Are you currently being treated for Crohn's disease? Yes No Don't know
	Ulcerative colitis	[IF SELECTED] Are you currently being treated for ulcerative colitis? Yes No Don't know
	Irritable bowel syndrome	[IF SELECTED] Are you currently being treated for irritable bowel syndrome? Yes No Don't know
	Celiac disease	[IF SELECTED] Are you currently being treated for celiac disease? Yes No Don't know
Liver or pancreas conditions	Yes, select all that apply No Don't know	
	Liver cirrhosis	[IF SELECTED] Are you currently being treated for liver cirrhosis?

Condition	Diagnosed	Are you currently being treated?
		Yes No Don't know
	Chronic hepatitis	[IF SELECTED] Are you currently being treated for chronic hepatitis? Yes No Don't know
	Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)	[IF SELECTED] Are you currently being treated for fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)? Yes No Don't know
Renal disease / kidney failure conditions	Yes, select all that apply No Don't know	
	Acute renal failure	[IF SELECTED] Are you currently being treated for acute renal failure? Yes No Don't know
	Chronic renal failure	[IF SELECTED] Are you currently being treated for chronic renal failure? Yes No Don't know
Mental health condition	Yes, select all that apply No Don't know	

Condition	Diagnosed	Are you currently being treated?
	Major depression	[IF SELECTED] Are you currently being treated for major depression? Yes No Don't know
	Minor depression	[IF SELECTED] Are you currently being treated for minor depression? Yes No Don't know
	Bipolar disorder	[IF SELECTED] Are you currently being treated for bipolar disorder? Yes No Don't know
	Post-traumatic stress disorder	[IF SELECTED] Are you currently being treated for post-traumatic stress disorder? Yes No Don't know
	Schizophrenia or Schizoaffective disorder	[IF SELECTED] Are you currently being treated for schizophrenia or schizoaffective disorder? Yes No Don't know
	Obsessive compulsive disorder	[IF SELECTED] Are you currently being treated for obsessive compulsive disorder? Yes No Don't know

Condition	Diagnosed	Are you currently being treated?
	Anxiety disorder	[IF SELECTED] Are you currently being treated for anxiety disorder? Yes No Don't know
	Eating disorder	[IF SELECTED] Are you currently being treated for an eating disorder? Yes No Don't know
	Addiction disorder (e.g. alcohol, drug or gambling dependence)	[IF SELECTED] Are you currently being treated for an addiction disorder (e.g. alcohol, drug or gambling dependence)? Yes No Don't know
Neurological conditions	Yes, select all that apply No Don't know	
	Thrombotic stroke	[IF SELECTED] Are you currently being treated for thrombotic stroke? Yes No Don't know
	Hemorrhagic stroke	[IF SELECTED] Are you currently being treated for hemorrhagic stroke? Yes No Don't know
	Multiple sclerosis	[IF SELECTED] Are you currently being treated for multiple sclerosis? Yes

Condition	Diagnosed	Are you currently being treated?
		No Don't know
Bone and joint conditions	Yes, select all that apply No Don't know	
	Arthritis Which type(s) of arthritis was it? Rheumatoid arthritis Osteoarthritis Don't know Other - please specify: _____	[IF SELECTED] Are you currently being treated for arthritis? Yes No Don't know
	Lupus	[IF SELECTED] Are you currently being treated for lupus? Yes No Don't know
	Fibromyalgia	[IF SELECTED] Are you currently being treated for fibromyalgia? Yes No Don't know
Skin conditions	Yes, select all that apply No Don't know	
	Eczema	[IF SELECTED] Are you currently being treated for eczema? Yes No Don't know
	Psoriasis	[IF SELECTED] Are you currently being treated for psoriasis? Yes

Condition	Diagnosed	Are you currently being treated?
		No Don’t know
	Scleroderma	[IF SELECTED] Are you currently being treated for scleroderma? Yes No Don’t know
Immune system conditions	Yes, select all that apply No Don’t know	
	HIV	[IF SELECTED] Are you currently being treated for HIV? Yes No Don’t know
	A weakened or compromised immune system (such as Severe Combined Immunodeficiency)	[IF SELECTED] Are you currently being treated for a weakened or compromised immune system (such as severe combined immunodeficiency)? Yes No Don’t know
	Hashimoto's thyroiditis, Sjögren’s syndrome, or Ankylosing spondylitis	[IF SELECTED] Are you currently being treated for Hashimoto's thyroiditis, Sjögren’s syndrome, or ankylosing spondylitis? Yes No Don’t know

Other Conditions

Do you have or have you had any other medical conditions?

Yes

No

Don’t know

[IF YES] Please list these medical conditions:
1: _____

Are you currently being treated for the other medical condition specified above?
Yes
No
Don't know

2: _____
Are you currently being treated for the other medical condition specified above?
Yes
No
Don't know

3: _____
Are you currently being treated for the other medical condition specified above?
Yes
No
Don't know

4: _____
Are you currently being treated for the other medical condition specified above?
Yes
No
Don't know

5: _____
Are you currently being treated for the other medical condition specified above?
Yes
No
Don't know

MC04. Have you ever received an organ, bone marrow, or stem cell transplant?
Yes
No
Don't know

MC05. [IF YES] Are you currently taking immunosuppressive medication?
Currently taking each day
Taken within the last few months (during the COVID-19 pandemic) but not every day
Taken before Jan 2020 but not currently
No

Don’t know

MC06. What is your blood type?
A
B
AB
O
Prefer not to answer
Don’t Know

MC07. Since March 2020, access to health services may have changed. Have you experienced any of the following changes related to your healthcare?
Select all that apply
Surgery cancelled or deferred
Medical procedure cancelled or deferred
Treatment cancelled or deferred
Other health-related appointment cancelled or deferred (e.g. dental, vision, etc.)
Use of virtual appointments with health care provider
Delayed seeing a healthcare professional about an existing problem or concern
Delayed seeing a healthcare professional about a new problem or concern
Regular lab tests cancelled or deferred
Medication shortage
Other – please specify:_____
None or not applicable

MEDICATION

ME01. Are you currently taking or have you taken in the past 12 months any of the medications listed below?
Yes, select all that apply
No
Don’t know

Medication Type	[IF YES] How often?
ACE-inhibitors to lower blood pressure (e.g. benazepril, captopril, enalapril, lisinopril, ramipril)	How often do or did you take ACE-inhibitors to lower blood pressure (e.g. benazepril, captopril, enalapril, lisinopril, ramipril)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don’t know

Medication Type	[IF YES] How often?
Angiotension II Receptor Blockers to lower blood pressure (e.g. candesartan, losartan, telmisartan, valsartan)	How often do or did you take angiotensin II receptor blockers to lower blood pressure (e.g. candesartan, losartan, telmisartan, valsartan)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Antibiotics	How often do or did you take antibiotics? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Antivirals (e.g. lopinavir-ritonavir, remdesivir)	How often do or did you take antivirals (e.g. lopinavir-ritonavir, remdesivir)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Allergy medications	How often do or did you take allergy medications? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Androgen deprivation therapy	How often do or did you take androgen deprivation therapy? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Asthma medications	How often do or did you take asthma medication? Currently taking each day

Medication Type	[IF YES] How often?
	Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Immunosuppressive or immunomodulatory medication (e.g. corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)	How often do or did you take immunosuppressive or immunomodulatory medication (e.g. corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Blood thinners (e.g. apixaban, rivaroxaban, dabigatran)	How often do or did you take blood thinners (e.g. apixaban, rivaroxaban, dabigatran)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Non-steroidal anti-inflammatory drugs (e.g. ibuprofen such as Advil or Motrin; naproxen such as Aleve)	How often do or did you take non-steroidal anti-inflammatory drugs (e.g. ibuprofen such as Advil or Motrin; naproxen such as Aleve)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know
Other pain/fever relievers (e.g. aspirin, paracetamol or acetaminophen)	How often do or did you take other pain/fever relievers (e.g. aspirin, paracetamol or acetaminophen)? Currently taking each day Taken within the last few months (during the COVID-19 pandemic) but not every day Taken before Jan 2020 but not currently Don't know

MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since March 2020 when COVID-19 was declared a pandemic. Please note that your responses will not be reviewed by a health professional. If you are experiencing stress or anxiety and would like to access support, please reach out to mental health services available in your area. Please follow the link for resources available in Alberta (https://www.albertahealthservices.ca/findhealth/Service.aspx?id=6810&serviceAtFacilityID=1047134)

PI01. Since March 2020, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half of the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

PI02. [IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all
Somewhat difficult
Very difficult
Extremely difficult

PI03. Since March 2020, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half of the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				

PI04. [IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all
Somewhat difficult
Very difficult
Extremely difficult

PI05. We would like you to compare your mental and emotional health before March 2020 to now.

	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
In general, would you say your current mental/emotional health is:					

	Better	**About the Same**	**Worse**
Your current mental/emotional health now compared to before March 2020:			

PI06. Stressful situations have the potential to affect the relationships around you. We understand that many things may have changed in your life due to the impact of COVID-19. In the next set of questions, we are interested in how your relationships have changed since March 2020.

My relationship with:	N/A	Has become closer than before the pandemic	Is about the same as before the pandemic	Is more distant or strained than before the pandemic
Intimate partner				
Other family members (excluding intimate partner)				
Friends				
Neighbours				
People you don't know but are in your community				
Work colleagues				

PI07. Since March 2020, have you accessed mental health services? (Select all that apply)
No
Yes - using resources that I already had in place
Yes – I have initiated new use of services
Prefer not to answer
Don't know

PI08. [IF YES] Did you access mental health services for any of the following conditions? (Select all that apply)
Anxiety
Depression
Stress
Other – please specify: _____
Prefer not to answer
Don't know

PI09. Since March 2020, has anyone in your household accessed mental health services? Select all that apply
No
Yes - using resources that they already had in place
Yes – they have initiated new use of services
Not applicable – I live alone
Prefer not to say
Don't know

SOCIAL & ECONOMIC IMPACT

The March, 2020 declaration of a global pandemic has devastated local communities and economies and many people have had their livelihoods affected. With this next set of questions, we want to understand how your family's ability to meet its essential needs and financial obligations have been impacted, and ask whether your family has given or received support in your community.

SI01. Prior to March 2020, what was your employment status? Full time means 30 hours or more per week. Part time means less than 30 hours per week. Select all that apply.
Full-time employed / self-employed
Part-time employed / self-employed
Retired
Looking after home and/or family
Unable to work because of sickness or disability
Unemployed
Doing unpaid or voluntary work
Student
Prefer not to answer

SI02. [IF YES to all except PNA] Has anything about your employment changed because of the pandemic (e.g. working from home)?
No
Yes

SI03. [IF YES] What has changed about your employment? Select all that apply.
Nature of work has changed
External workplace has changed
Work from home
Reduced wages/ hours
Loss of employment
Redeployed into healthcare for pandemic response
Redeployed into other essential services for pandemic response
Other – please specify: _____
Prefer not to answer

SI05. Prior to the pandemic, what was your approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.
Less than $10,000
$10,000 - $24,999
$25,000 - $49,999
$50,000 - $74,999
$75,000 - $99,999
$100,000 - $149,999
$150,000 - $199,999
$200,000 or more
Prefer not to answer
Don't know

SI06. Has your monthly household income been changed because of the COVID-19 pandemic?
Substantially decreased

Somewhat decreased
No change
Somewhat increased
Substantially increased

SI07. Have your household savings been changed because of the COVID-19 pandemic?
Substantially decreased
Somewhat decreased
No change
Somewhat increased
Substantially increased

SI08. Which of the following best describes the impact of COVID-19 on your ability to meet financial obligations or essential needs, such as rent or mortgage payments, utilities and groceries?
Major impact
Moderate impact
Minor impact
No impact
Too soon to tell

SI09. Since March 2020, has anyone in your household ever received food from a food bank, soup kitchen or other charitable agency?
Yes
No
Prefer not to answer
Don't know

SI10. [IF YES] How many times? ____

SI11. On a scale of 1 to 7, please indicate how much you worry about having enough money to do what is important for you/your family:
Rarely/never --- Always

SI12. On a scale of 1 to 7, please indicate if you have the financial resources you need to meet you/your family's needs:
Rarely/never --- Always

We'd like to ask you about giving and receiving support during the pandemic.

SI13. Since March 2020, have you provided help, aid or support to others (friends, family, neighbours, community/volunteer organization, colleagues) because of the pandemic?
Yes
No

Don’t know

SI14. [IF YES] What kind of help, aid or support did you provide and for whom? (Select all that apply)

	Emotional/ psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods/donations (e.g. furniture, clothing)
Family (spouse, parent, other relatives)						
Friend(s)/ Neighbour(s)						
Community /volunteer organization						
Colleagues						

SI15. Since March 2020, have you looked for help, aid or support (including from friends, family, community or government) because of the pandemic?
Yes
No
Don’t know

SI16. Since March 2020, have you received help, aid, information or support (including from friends, family, community or government) because of the pandemic?
Yes
No
Don’t know

SI17. [IF YES] what kind of help, aid or support did you receive and from whom? (Check all that apply)

	Emotional/ psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods/donations (e.g. furniture, clothing)
Family (spouse, parent, other relatives)						
Friend(s)/ Neighbour(s)						
Community/ volunteer organization						
Colleagues						
Professional (doctor, lawyer, teacher,						

	Emotional/ psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods/donations (e.g. furniture, clothing)
counsellor, spiritual leader, financial advisor)						
General media (TV, internet, social media)						
Provincial or Federal Health authorities (e.g. help/information phone lines, websites, social media)						
Government (financial support, financial relief, resources)						

ANTHROPOMETRICS

Not only does our height and weight change as we age, the COVID-19 pandemic may have caused changes in your eating and activity habits. Please tell us your current height and weight, following the measurement instructions provided.

AM01. How tall are you?

Please answer the question using feet and inches or centimeters.
Feet_____ & Inches_____
Centimetres_____
Prefer not to answer
Don't know

AM02. How much do you weigh?

Adjust your scale to zero;
Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.
Step on the scale. Make sure both feet are fully on the scale.
Record your weight in pounds or kilograms.
Pounds_____
Kilograms_____
Prefer not to answer
Don't know

ATP ADDITIONAL QUESTIONS - OPTIONAL FOR PARTICIPANTS

COVID-19 has prompted us to revisit some of our activities of daily living, and to find ways to cope during store closures, working from home, and physical distancing. We are interested in activities you have been able to enjoy more since COVID-19. (Select ALL that apply)
Domestic activities (e.g., cooking, cleaning, de-cluttering)
Household projects (e.g., renovations, gardening)
New or re-kindled hobbies (e.g., arts and crafts, reading books, writing, blogging)
Spending more time with family or housemates doing activities (e.g. playing board games)
Educational activities (e.g. online language course)
Physical fitness or self-care (e.g., yoga, running, strength training, meditation)
Connecting with friends and family (e.g. using video or phone calls)
Other – (text box)
None

We'd like to ask you a few more questions about your health and diet/nutrition and physical activity habits.

In general, would you say your health is:
Excellent
Very good
Good
Fair
Poor

For the next five questions, please indicate which statements best describe your own state of health today by selecting one option in each group.

Mobility
I have no problems in walking about
I have slight problems in walking about
I have moderate problems in walking about
I have severe problems in walking about
I am unable to walk about

Self-Care
I have no problems washing or dressing myself
I have slight problems washing or dressing myself
I have moderate problems washing or dressing myself
I have severe problems washing or dressing myself
I am unable to wash or dress myself

Usual activities (e.g. work, study, housework, family or leisure activities)
I have no problems doing my usual activities
I have slight problems doing my usual activities

I have moderate problems doing my usual activities
I have severe problems doing my usual activities
I am unable to do my usual activities

Pain/discomfort
I have no pain or discomfort
I have slight pain or discomfort
I have moderate pain or discomfort
I have severe pain or discomfort
I have extreme pain or discomfort

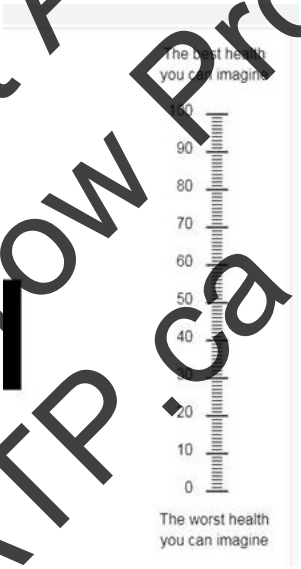
Anxiety/depression
I am not anxious or depressed
I am slightly anxious or depressed
I am moderately anxious or depressed
I am severely anxious or depressed
I am extremely anxious or depressed

We would like to know how good or bad your health is TODAY.

This scale is numbered from 0 to 100.

100 means the best health you can imagine.
0 means the worst health you can imagine.

Please click on the scale to indicate how your health is TODAY.



We are interested in how your diet/nutrition habits may have changed since March 2020 (the start of the provincial public health emergency). For the next few questions, please compare your current behaviours to your previous behaviours (before March 2020) when responding.

Food sources

	A lot less	A little less	About the same	A little more	A lot more	Not applicable
Preparing and/or cooking meals at home						
Baking at home						
Meal planning						
Budgeting for food or food shopping more carefully						
Visiting the grocery store						
Using grocery or food/meal delivery services (e.g., Hello Fresh, GoodFood, etc.)						

Eating patterns/habits

	A lot less	A little less	About the same	A little more	A lot more	Not applicable
Eating restaurant food (please consider restaurant food overall, including dining in takeout and delivery)						
Snacking						
Reaching for 'comfort' foods						
Skipping meals						
Thinking about or being pre-occupied with food						
Having food go to waste						
Eating alone						

Eating with others (including family)						

Types of foods

	A lot less	A little less	About the same	A little more	A lot more	Not applicable
Eating fresh fruit and vegetables						
Eating frozen/canned fruit and vegetables						
Eating brown rice, whole grain pasta or bread, oats, barley and other whole grains						
Eating meat, poultry, fish, dairy and other animal proteins						
Eating nuts, beans, peas, lentils, tofu/soy products and other plant proteins						
Eating packaged or prepared foods						

Which of the following statements best describes the food eaten in your household in the past 12 months, that is since MM of last year?

You and other household members always had enough of the kinds of foods you wanted to eat.
You and other household members had enough to eat but not always the kinds of foods you wanted.
Sometimes you and other household members did not have enough to eat.

Often you and other household members didn't have enough to eat.
Prefer not to answer
Don't know

We are interested in how your physical activity habits may have changed since March 2020 (the start of the provincial public health emergency). For the next few questions, please compare your current behaviours to your previous behaviours (before March 2020) when responding.

Walking

	A lot less	A little less	About the same	A little more	A lot more	Not applicable
Walk in my neighbourhood alone						
Walk in my neighbourhood with family members						
Walk to a store, café, or shop						
Walk to work						

Locations of Activities

	A lot less	A little less	About the same	A little more	A lot more	Not applicable
Be physically active inside my home						
Be physically active in a facility outside my home						
Be physically active outdoors alone						
Be physically active outdoors with family members						
Drive in motor vehicle (in your vehicle or with someone else)						
Spend time outdoors						

Visit parks						
Use pathways						

Types of Activities

	A lot less	A little less	About the same	A little more	A lot more	Not applicable
Use online workout videos						
Do cardio-based activity						
Do weight training or bodyweight based activity						
Watch television						
Use screen-based devices (smart phone, computers, etc. - not television)						
Play video games						
Interact with your neighbour face to face						
Talk to others in your neighbourhood face to face (at a park, on a sidewalk or pathway)						

C_ATP_PETS. Do you have pets in your household? (Select all that apply)
Yes – dog(s)
Yes – cat(s)
Yes – bird(s)
Yes – other(s)
No
Don't know

We are interested in how people are staying up to date and learning about COVID-19. Which are the main sources you have used for information on COVID-19? (Select all that apply)

News outlets including local, national and international sources
Provincial daily announcements by public health and political leaders (e.g. Dr. Deena Hinshaw, Alberta Chief Medical Officer of Health)
Federal daily announcements by public health and political leaders (e.g. Dr. Theresa Tam, Chief Public Health Officer)
Municipal health agency (e.g. website, public service announcements)
Provincial health agency (e.g. Alberta Health Services or Alberta Health website, public service announcements)
Federal health agency (e.g. Public Health Agency of Canada website, public service announcements)
Social media (e.g. Facebook, Instagram, Twitter, SnapChat, TikTok, YouTube)
Family, friends or colleagues
Health professionals
Schools, universities, colleges (e.g. email, website)
Place of employment
Other
or
None of the above

[If any chosen except for Other or None; only show options they chose from the above question) How informative do you find this source? Here, informative refers to something that is useful, helpful and relevant. Please choose an option from 1 (not at all informative) to 5 (very informative).

	1 Not at all	2	3	4	5 Very
News outlets					
Provincial daily announcements by public health and political leaders					
Federal daily announcements by public health and political leaders					
Municipal health agency					
Provincial health agency					
Federal health agency					
Social media					
Family, friends or colleagues					
Health professionals					
Schools, universities, colleges					
Place of employment					

[If any chosen except for Other or None) Which source of information did you find the most helpful (choose one)?
(*show options they chose from above and allow one choice*)

Thank you for responding to our COVID-19 survey. The following is a list of questions to help us understand how well we did with this survey administration. Your feedback is valuable to us and will help us plan for future survey deliveries.

What drew you to complete this survey? (Select all that apply)

Because I am an ATP participant
Because I would like to contribute to the understanding of COVID-19
Other (open text)

How would you rate your experience completing this survey?

Excellent – did not encounter challenges
Good – encountered minimal challenges
Neutral
Poor – encountered some challenges
Very poor – encountered many challenges

Why did you give this rating? (open text)

How would you rate the invitation asking you to participate in the COVID-19 survey?

Excellent
Good
Neutral
Poor
Very poor

Why did you give this rating? (open text)

Did you feel the frequency of the survey reminder emails was appropriate?

Yes
No

In your opinion, how can we continue to keep you engaged in future data collections? (open text)

This is the end of the questionnaire! Thank you for taking the time to complete this questionnaire!