

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
			COVID-19 QUESTIONNAIRE SPECIFICATIONS <u>CRITERIA</u> INTTYPE=ALL SPALIVE=1 SEASON=WINTER SPPROXY=SP or PROXY Other: N/A <u>PLACEMENT</u> Administer after IMQ.		
	BOX CVBEG	routing	IF SP HAS NEVER REPORTED A DOSE OF COVID-19 VACCINE [P_VAXCOUNT=.] GO TO VACCDOSE, ELSE GO TO BOX CV1.		
VACCDOSE	VACCDOSE	yes/no	The next questions are about coronavirus or COVID-19 vaccination. [Have you/Has (SP)] had at least one dose of a COVID-19 vaccine? IF NEEDED: Please include booster shots. IF NEEDED: This question is asking for the total number of COVID-19 vaccine doses that [you have/(SP) has] received since the vaccine first became available in December 2020.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	(01) BOX CV1 (02) BOX CV1 (-8) BOX CV2 (-9) BOX CV2
	BOX CV1	routing	IF SP DID NOT REPORT ANY DOSES OF VACCINE [VACCDOSE=2/NO] GO TO NOVCREAS, ELSE IF SP HAS PREVIOUSLY REPORTED FOUR OR MORE DOSES OF COVID-19 VACCINE [P_VAXCOUNT=1] GO TO PREVYRDS, ELSE GO TO DOSENUMB.		
DOSENUMB	DOSENUMB	code one	Since December 2020, how many COVID-19 vaccinations [have you/has (SP)] received in total? IF NEEDED: Please include booster shots and any additional doses. IF NEEDED: This question is asking for the total number of COVID-19 vaccine doses that [you have/(SP) has] received since the vaccine first became available in December 2020.	(01) 1 VACCINATION (02) 2 VACCINATIONS (03) 3 VACCINATIONS (04) 4 OR MORE VACCINATIONS (-8) DON'T KNOW (-9) REFUSED	PREVYRDS
PREVYRDS	PREVYRDS	yes/no	In [PREVIOUS YEAR], did [you/(SP)] receive at least one dose of the COVID-19 vaccine? IF NEEDED: Please include booster shots.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	(01) BOX CV2 (02) NOVCREAS (-8) BOX CV2 (-9) BOX CV2
NOVCREAS	NOVCREAS	code all	Why did [you/(SP)] not get a COVID-19 vaccine [in [PREVIOUS YEAR]]? [PROBE: Any other reason?] DO NOT READ ALOUD. CODE BASED ON WHAT THE RESPONDENT SAYS. CHECK ALL THAT APPLY. IF R IS NOT ELIGIBLE FOR THEIR NEXT DOSE, SELECT "NOT YET ELIGIBLE TO RECEIVE COVID-19 BOOSTER DOSE."	(01) NOT YET ELIGIBLE TO RECEIVE COVID-19 BOOSTER DOSE (02) PLANS TO GET A BOOSTER AND IS ELIGIBLE, BUT HASN'T YET (03) THINKS THEY HAVE ENOUGH IMMUNITY TO COVID-19 FROM PRIOR DOSES OF THE VACCINE (04) NOT WORRIED ABOUT GETTING COVID-19 (10) DOCTOR HAS NOT RECOMMENDED IT (05) ALREADY HAD COVID-19 (07) NOT REQUIRED TO GET A COVID-19 BOOSTER (BY WORK OR SCHOOL) (08) EXPERIENCED SIDE EFFECTS FROM PREVIOUS DOSE(S) OF THE COVID-19 VACCINE (91) OTHER (-8) DON'T KNOW (-9) REFUSED	(01)-(10), (-8), (-9), BOX CV2 (91) NOVACOS
NOVACOS	NOVACOS	verbatim	OTHER (SPECIFY)	(01) CONTINUOUS ANSWER	BOX CV2
	BOX CV2	routing	IF INTTYPE is C007 [sample_person.INTTYPE=7], GO TO EVRHDCVD, ELSE GO TO TSTCVDYR.		

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EVRHDCVD	EVRHDCVD	yes/no	[Have you/Has (SP)] ever tested positive for COVID-19 or been told by a doctor or other health care provider that [you have/(SP) has] or had COVID-19? [IF NEEDED: Some COVID-19 tests are done by swabbing the nose or mouth to test for COVID-19 infection at the time of the test. Other tests look for COVID-19 antibodies by looking at someone’s blood to see if they have ever been infected with COVID-19. COVID-19 tests can be done at home by yourself or by someone else, and some tests are done by a health professional.] <u>INCLUDE ANTIBODY TESTS</u> , WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH COVID-19.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	TSTCVDYR
TSTCVDYR	TSTCVDYR	yes/no	In [PREVIOUS YEAR], [were you/was (SP)] tested at least one time to see whether [you were/(SP) was] infected with COVID-19? [IF NEEDED: For example, the test can be done by swabbing the nose or mouth. Some tests can be done by yourself or by someone else at home, and some tests are done by a health professional.] <u>INCLUDE ANTIBODY TESTS</u> , WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH COVID-19.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	(01) TESTTYPE (02) BOX CV3 (-8) BOX CV3 (-9) BOX CV3
TESTTYPE	TESTTYPE	code all	What kind of test(s) did [you/(SP)] take? A nasal or throat swab or saliva test that was collected or read by a health care professional, an at-home test that was read by [yourself/(SP)] or a non-health care professional, or a blood test to look for COVID-19 antibodies? SELECT ALL THAT APPLY	(01) NASAL OR THROAT SWAB OR SALIVA TEST THAT WAS COLLECTED OR READ BY A HEALTH CARE PROFESSIONAL (02) AT-HOME TEST THAT WAS READ BY [YOURSELF/(SP)] OR A NON-HEALTH CARE PROFESSIONAL (03) BLOOD TEST TO LOOK FOR COVID-19 ANTIBODIES (-8) DON'T KNOW (-9) REFUSED	CVDRSLT
CVDRSLT	CVDRSLT	code one	Did the test(s) find that [you/(SP)] had -COVID-19? [IF NEEDED: If [you/(SP)] had more than one test in [PREVIOUS YEAR] to see whether [you were/(SP) was] infected with COVID-19, answer yes if any of them were positive.] <u>INCLUDE ANTIBODY TESTS</u> , WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH COVID-19.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	(01) CVDSVRE (02) BOX CV3 (-8) BOX CV3 (-9) BOX CV3
CVDSVRE	CVDSVRE	code one	When [you/(SP)] had COVID-19 in [PREVIOUS YEAR], how would you describe [your/(SP)’s] COVID-19 symptoms when they were at their worst? Would you say [you/(SP)] had no symptoms, mild symptoms, moderate symptoms, or severe symptoms?	(01) NO SYMPTOMS (02) MILD SYMPTOMS (03) MODERATE SYMPTOMS (04) SEVERE SYMPTOMS (-8) DON'T KNOW (-9) REFUSED	CVDSEEK
CVDSEEK	CVDSEEK	yes/no	In [PREVIOUS YEAR], did [you/(SP)] seek medical care for-COVID-19?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	CVDHOSP
CVDHOSP	CVDHOSP	yes/no	In [PREVIOUS YEAR] [were you/was (SP)] hospitalized overnight for COVID-19? [IF NEEDED: This could include visiting the emergency room or being admitted to the hospital.]	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED	BOX CV3
	BOX CV3	routing	If Respondent has ever had COVID-19 [EVRHDCVD=1/YES] OR tested positive for COVID in the previous year [CVDRSLT =1/YES], GO TO LONGCVD. ELSE, go to BOX CVEND.		
LONGCVD	LONGCVD	yes/no	Did [you/(SP)] have any symptoms lasting 3 months or longer that [you/(SP)] did not have prior to having COVID-19? [IF NEEDED: Long term symptoms may include tiredness or fatigue, difficulty thinking, concentrating, forgetfulness or memory problems, sometimes referred to as "brain fog," difficulty breathing or shortness of breath, joint or muscle pain, fast-beating or pounding heart (also known as heart palpitations), chest pain, dizziness on standing, depression, anxiety or mood changes.]	(01) YES (02) NO (03) NOT APPLICABLE, RECENTLY DIAGNOSED WITH COVID-19 (LESS THAN THREE MONTHS) (-8) DON'T KNOW (-9) REFUSED	BOX CVEND
	BOX CVEND	routing	GO TO KNQ.		