Table 1: Supplemental COVID-19 questions

1) Have you had any of the following symptoms in the past 14 days?
   a) Fever or chills Y/N
   b) Cough Y/N
   c) Shortness of breath or difficulty breathing Y/N
   d) Fatigue Y/N
   e) Muscle or body aches Y/N
   f) Headache Y/N
   g) New loss of taste or smell Y/N
   h) Sore throat Y/N
   i) Congestion or runny nose Y/N
   j) Nausea or vomiting Y/N
   k) Diarrhea Y/N
   l) date symptoms started ________
   m) date symptoms resolved ________

2) Have you ever had a positive test for COVID-19? Y/N
   a) If yes:
      i) Date of test ________
      ii) Were you tested because you had symptoms? Y/N
         (1) If yes:
            (a) Date symptoms started _______
            (b) Date symptoms resolved ________
            (c) Were you hospitalized? Y/N
      iii) Were you tested because you were exposed to someone with COVID-19, but you did not have any symptoms? Y/N

3) Have you ever had a positive test for COVID-19 antibodies Y/N
   a) If yes: Date of test ________

4) Has anyone living in your household had any of the following symptoms or tested positive for COVID-19 in the past 14 days? Y/N

   i) If Yes, circle the applicable symptoms.
   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing

- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

5) Have you been within 6 feet for more than 15 minutes of someone with COVID-19 in the past 14 days? Y/N
    i) If yes: date(s) of exposure __________