Consent

Record ID	______________________

Consent

Is consent required for this study?	◯ Yes, consent is required for this study ◯ No, Consent is not required/is waived for this study
Date of Consent	______________________ (MM/DD/YYYY)
I agree to let The Duke Clinical Research Institute to collect all identifiable information.	◯ Yes ◯ No (This is to enable linkage of deidentified data.)
I agree to let The Duke Clinical Research Institute to collect my Social Security number.	◯ Yes ◯ No
I agree to let The Duke Clinical Research Institute to collect only my zip code and no other identifiable information.	◯ Yes ◯ No
I agree to be contacted for future research.	◯ Yes ◯ No

Location

County ______________________

Zip Code ______________________

Sociodemographics

Date of Sociodemographic Data Collection

____
(MM/DD/YYYY)

Demographics

What is your race?

Mark one or more boxes AND print origins.

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Some other race
- ☐ Prefer not to answer

(Check all that apply)

- ☐ Japanese
- ☐ Filipino
- ☐ Chinese
- ☐ Korean
- ☐ Other Asian

(Check all that apply)

- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Samoan
- ☐ Tongan
- ☐ Maori
- ☐ Fijian
- ☐ Chamorro
- ☐ Chuukese
- ☐ Kosraen
- ☐ Marshallese
- ☐ Palauan
- ☐ Pohnpeian
- ☐ Yapese
- ☐ Other Pacific Islander

(Check all that apply)

Specify other origin.

Print race of origin.

____

Are you of Hispanic, Latino, or Spanish origin?

- ◯ No, not of Hispanic, Latino, or Spanish origin
- ◯ Yes, of Hispanic, Latino, or Spanish origin
- ◯ Prefer not to answer

Please specify your origin

- ◯ Mexican, Mexican Am., Chicano
- ◯ Puerto Rican
- ◯ Cuban
- ◯ Another Hispanic, Latino, or Spanish origin

Please specify other Hispanic, Latino, or Spanish origin. For example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.

____

Age For babies less than 1 year old, do not write the age in months. Write 0 as the age.	______________________ (Years)
What was your sex assigned at birth?	◯ Female ◯ Male ◯ Non-binary ◯ None of these describe me ◯ Prefer not to answer
What terms best express how you describe your gender identity?	◯ Woman ◯ Man ◯ Non-binary ◯ Transgender man/Female-to-male (FTM) ◯ Transgender woman/Male-to-female (MTF) ◯ Gender non-binary/Genderqueer/Gender nonconforming ◯ Agender ◯ Bigender ◯ None of these describe me ◯ Prefer not to answer
Are you currently pregnant?	◯ Pregnant ◯ Not Pregnant ◯ Don't know ◯ Prefer not to answer
Which of the following best represents how you think of yourself at this time?	◯ Gay ◯ Lesbian ◯ Straight; that is, not gay or lesbian, etc. ◯ Bisexual ◯ None of these describe me ◯ Prefer not to answer
What is the highest level of education you have achieved outside or in the United States? Grades roughly equivalent to years of school.	◯ Have never gone to school ◯ 5th grade or less ◯ 6th to 8th grade ◯ 9th to 12th grade, no diploma ◯ High school graduate or GED completed ◯ Some college level/ Technical / Vocational degree ◯ Bachelor's degree ◯ Other advanced degree (Master's, Doctoral degree) ◯ Prefer not to answer ◯ Don't know

Housing Employment And Insurance

Housing

Question	Response
Date of Housing, Employment and Insurance Collection	________________ (MM/DD/YYYY)
What best describes your family at home:	◯ Just me ◯ Living with spouse, no kids ◯ Family including kids ◯ Family with 3 generations (parents, children, grandchildren) ◯ Family with 4 generations ◯ None of these
Are you currently living in transitional housing, staying in a shelter, or experiencing homelessness?	◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know
Do you live in any of these?	◯ A group care setting ◯ Nursing home ◯ Residential care facility for people with intellectual and developmental disabilities ◯ A psychiatric treatment facility ◯ A group home ◯ A board and care home ◯ Prison or jail ◯ A halfway house ◯ Foster care ◯ Somewhere else
Where do you stay/live?	________________

Employment

Question	Response
Have you, or has anyone in your household, experienced a loss of employment income since the start of the COVID-19 pandemic (March 2020)?	◯ Yes ◯ No
We would like to know about what you do -- are you working now, looking for work, retired, keeping house, a student, or something else?	◯ Working now ◯ Only temporarily laid off, sick leave or maternity leave ◯ Looking for work, unemployed ◯ Retired ◯ Disabled, permanently or temporarily ◯ Keeping house ◯ Student ◯ Other (Specify) ◯ Prefer not to answer ◯ Don't know
Current employment status, Other - specify	________________

Are you considered an essential worker? An essential worker is someone who was required to go to work even when stay at home orders were in place	◯ Yes ◯ No ◯ Prefer not to answer ◯ Unknown
Would any of these describe where you work?	◯ Nursing care facilities ◯ Visiting nurse or home health aide service ◯ Building cleaning services ◯ Public transportation ◯ Corrections facility ◯ EMT or paramedic services ◯ Meat packing farm facility ◯ Agriculture and food production facility ◯ Grocery store ◯ Construction ◯ No
What is the primary kind of health insurance or health care plan that you have now?	◯ I do NOT have health insurance ◯ Private (purchased directly or through Employment) ◯ Public (Medicare, Medicaid, Tricare) ◯ Don't know ◯ Prefer not to answer (Exclude plans that pay for only one type of Service (such as, nursing home care, accidents, family planning, or dental care) and plans that only provide extra cash when hospitalized.)
Did you lose health coverage because of the COVID-19 pandemic?	◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know

The COVID-19 pandemic may cause challenges for some people, whether they get COVID-19 or not. In the past 6 months have you or your family experienced any of the below challenges?

Getting the health care I need (including for mental health)	◯ No, not a challenge ◯ Yes, a minor challenge ◯ Yes, this is a major challenge
Having a place to stay/live	◯ No, not a challenge ◯ Yes, a minor challenge ◯ Yes, this is a major challenge
Getting enough food to eat	◯ No, not a challenge ◯ Yes, a minor challenge ◯ Yes, this is a major challenge
Having clean water to drink	◯ No, not a challenge ◯ Yes, a minor challenge ◯ Yes, this is a major challenge
Getting the medicine I need	◯ No, not a challenge ◯ Yes, a minor challenge ◯ Yes, this is a major challenge
Getting to where I need to go	◯ No, not a challenge ◯ Yes, a minor challenge ◯ Yes, this is a major challenge

Spoken Language

Do you speak a language other than English at home?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

What language(s)

- ☐ Spanish
- ☐ Vietnamese
- ☐ Mandarin
- ☐ Cantonese
- ☐ Tagalog
- ☐ Hawaiian
- ☐ Ilokano
- ☐ Navajo
- ☐ Other

(For projects/sites needing additional languages, please reach out to your EIT lead to have additional languages added to the base instrument for coding consistency. Thank you.)

Specify other language(s)

____

Family Income

In 2019, what was your total household income before taxes?

- ◯ Less than $15,000
- ◯ $15,000 - $19,999
- ◯ $20,000 - $24,999
- ◯ $25,000 - $34,999
- ◯ $35,000 - $49,999
- ◯ $50,000 - $74,999
- ◯ $75,000 - $99,999
- ◯ $100,000 and above
- ◯ Prefer not to answer

Work Ppe And Distancing

Date of Work PPE and Distancing Collection	__________________________________ (MM/DD/YYYY)
In your workplace, do you have access to necessary facilities to wash?	◯ Yes, all of the time ◯ Yes, most of the time ◯ Some of the time ◯ Rarely ◯ Not at all
Does your work require you to be in close contact (i.e. within 6 ft) with others?	◯ Yes, all of the time ◯ Yes, most of the time ◯ Some of the time ◯ Rarely ◯ Not at all
In your workplace, do you have access to necessary personal protective equipment (PPE)?	◯ Yes, all of the time ◯ Yes, most of the time ◯ Some of the time ◯ Rarely ◯ Not at all ◯ Not applicable

Medical History

Medical History

Date of Medical History Collection

____
(MM/DD/YYYY)

Conditions

Do you have any of the following conditions? (Select all that apply)

Condition	Response
Immunocompromised condition	◯ Yes ◯ No
Autoimmune disease	◯ Yes ◯ No
Hypertension (HTN, high blood pressure)	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No
Chronic kidney disease (CKD)	◯ Yes ◯ No
Cancer diagnosis and/or treatment within the past 12 months	◯ Yes ◯ No
Cardiovascular disease (CVD or heart disease)	◯ Yes ◯ No
Asthma	◯ Yes ◯ No
Chronic obstructive pulmonary disease (COPD)	◯ Yes ◯ No
Other chronic lung disease	◯ Yes ◯ No
Sickle Cell Anemia	◯ Yes ◯ No
Depression	◯ Yes ◯ No
Alcohol or substance use disorder	◯ Yes ◯ No
Intravenous drug use	◯ Yes ◯ No
Other mental health disorder	◯ Yes ◯ No
Other chronic condition	◯ Yes ◯ No

Health Status

Date of Health Status Collection

____
(MM/DD/YYYY)

Height

How tall are you without shoes?

Please choose the units you would like to use for height

- ◯ Feet and inches
- ◯ Meters and centimeters
- ◯ Don't know
- ◯ Prefer not to answer

Feet

____

Inches

____

Meters

____

Centimeters

____

Weight

Please choose the units you would like to use for weight

- ◯ Kilograms
- ◯ Pounds

How much do you weigh without clothes or shoes?

If you are currently pregnant, how much did you weigh before your pregnancy?

____

How much do you weigh without clothes or shoes?

If you are currently pregnant, how much did you weigh before your pregnancy?

____

Self-reported Health

Would you say your health in general is excellent, very good, good, fair, or poor?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Prefer not to answer
- ◯ Don't know

Do you have a disability that interferes with your ability to carry out daily activities? Examples of daily activities include walking, climbing stairs, shopping, balancing a checkbook, bathing or dressing.

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Vaccine Acceptance

Date of Vaccine Acceptance Collection

____
(MM/DD/YYYY)

Vaccination

Have you ever received a flu vaccination?

- ◯ Yes
- ◯ No
- ◯ Do not remember

Have you received a flu vaccine this season (last 6 months)?

- ◯ Yes
- ◯ No
- ◯ Do not remember

Have you received a COVID-19 vaccine?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer
- ◯ Don't know

How likely are you to get an approved COVID-19 vaccine when it becomes available?

- ◯ Very likely
- ◯ Fairly likely
- ◯ Not too likely
- ◯ Not at all likely
- ◯ Definitely not
- ◯ Don't know
- ◯ Prefer not to answer
- ◯ Not applicable

Reasons for Getting/Not Getting a COVID 19 Vaccine

Why would you get a COVID-19 vaccine?

- ☐ I want to keep my family safe
- ☐ I want to keep my community safe
- ☐ I want to keep myself safe
- ☐ I have a chronic health problem, like asthma or diabetes
- ☐ My doctor told me to get a COVID-19 vaccine
- ☐ I don't want to get really sick from COVID-19
- ☐ I want to feel safe around other people
- ☐ I believe life won't go back to normal until most people get a COVID-19 vaccine
- ☐ Other

(Check all that apply)

Why would you NOT get a COVID-19 vaccine?

- ☐ I'm allergic to vaccines
- ☐ I don't like needles
- ☐ I'm not concerned about getting really sick from COVID-19
- ☐ I'm concerned about side effects from the vaccine
- ☐ I don't think vaccines work very well
- ☐ I don't trust that the vaccine will be safe
- ☐ I don't believe the COVID-19 pandemic is as bad as some people say it is
- ☐ I don't want to pay for it
- ☐ I don't know enough about how well a COVID-19 vaccine works
- ☐ Other

(Check all that apply)

Testing

Date of Testing Collection

____
(MM/DD/YYYY)

If you were to test positive for COVID-19, would you be able to isolate without losing your job?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

If you would be exposed to someone with COVID-19, would you be able to quarantine without losing your job?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Tested previously for COVID-19

Have you ever been tested for COVID-19?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Tested positive for COVID-19

Have you ever tested positive for COVID-19?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What month did you first test positive for COVID-19?

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December

What year did you first test positive for COVID-19?

- ◯ 2019
- ◯ 2020
- ◯ 2021

What month did you have your most recent COVID-19 test?	◯ January ◯ February ◯ March ◯ April ◯ May ◯ June ◯ July ◯ August ◯ September ◯ October ◯ November ◯ December
What year did you have your most recent COVID-19 test?	◯ 2019 ◯ 2020 ◯ 2021
What was the result of your most recent COVID-19 test?	◯ Negative ◯ Positive ◯ Never obtained results ◯ Indeterminate ◯ Don't know ◯ Prefer not to answer
How were you tested for your most recent test?	◯ Nasal Swab ◯ Throat Swab ◯ Blood Sample ◯ Saliva

Accessibility to testing

I know where I can get COVID-19 testing in my community.	◯ Strongly disagree ◯ Disagree ◯ Neither disagree or agree ◯ Agree ◯ Strongly agree
It is easy to get tested for COVID-19.	◯ Strongly disagree ◯ Disagree ◯ Neither disagree or agree ◯ Agree ◯ Strongly agree

Covid Test

This is for projects that are doing acute testing. To collect as part of the testing procedure by the study team. For many projects some of these fields may be prefilled, such as location, method target, test name, specimen type, specimen collector. Testing results will need to be filled in after collection

Date of COVID Test Information Collection ________________________________

Testing Information

Participant Testing Disease Status
- ◯ Asymptomatic
- ◯ Pre-symptomatic illness
- ◯ Mild/Moderate outpatient illness
- ◯ Acute illness
- ◯ Severe/Critical inpatient illness
- ◯ Exposed
- ◯ Convalescent illiness

Quality and Regulatory
- ◯ CLIA/CP certified
- ◯ CLIA Waiver
- ◯ FDA authorized (EUA)
- ◯ FDA cleared
- ◯ LDT
- ◯ Other (specify)

Other approval ________________________________

Test Collection Setting
- ◯ Clinic
- ◯ Drive-through
- ◯ Home
- ◯ Mobile unit
- ◯ Lab
- ◯ Mail-in
- ◯ Community location (e.g., church, school, community center, etc.)
- ◯ Other, Specify

Other setting ________________________________

Test Performed Location
- ◯ Clinic
- ◯ Drive-through
- ◯ Home
- ◯ Mobile unit
- ◯ Lab
- ◯ Mail-in
- ◯ Community location (e.g., church, school, community center, etc.)
- ◯ Other, Specify

Other performed location ________________________________

Study Setting	◯ Community health center ◯ Nursing home or long-term care facility ◯ Prison or correctional facility ◯ Public housing ◯ Rural ◯ Urban ◯ School ◯ In-home ◯ Other, Specify
Other study setting	______________________________
Test Method Target	◯ Antibody ◯ Antigen ◯ Nucleic acid/PCR ◯ Nucleic acid/Isothermal ◯ Molecular/host response ◯ Biochemical marker (eg, pH) ◯ Other, Specify
Other method target	______________________________
Test manufacturer (or LDT) and test name	______________________________
Specimen Type	◯ Anterior nasal swab ◯ Mid-turbinate nasal swab ◯ Nasopharyngeal swab ◯ Oropharyngeal swab ◯ Nasal lavage ◯ Saliva ◯ Sputum ◯ Whole blood ◯ Other, Specify
Other specimen type	______________________________
Specimen Collector	◯ Self-collect ◯ Health Care Provider collected ◯ Other, Specify
Other specimen collector	______________________________
Date and time specimen collected	______________________________
Date and time result received	______________________________
Date and time result sent to participant	______________________________
Raw test result (if not a Positive/Negative/Failed report)	______________________________

Test result	◯ Positive ◯ Negative ◯ Failed ◯ Lost ◯ Other
Other test result	__________________________________

Symptoms

This is for projects that are doing acute testing. To collect as part of the testing procedure by the study team.

Date of Symptom Collection

__________________ (MM/DD/YYYY)

Current Symptoms

Have you had any of these symptoms during the past week?

	Yes	No	Don't know
Fever or chills	○	○	○
Cough	○	○	○
Shortness of breath or difficulty breathing	○	○	○
Lack of energy or general tired feeling	○	○	○
Muscle or body aches	○	○	○
Headache	○	○	○
New loss of taste or smell	○	○	○
Sore throat, congestion or runny nose	○	○	○
Feeling sick to your stomach or vomiting, diarrhea	○	○	○
Abdominal Pain	○	○	○
Skin Rash	○	○	○
Other	○	○	○

Alcohol And Tobacco

Date of Alcohol/Tobacco Use Collection

____
(MM/DD/YYYY)

Alcohol and Tobacco/Nicotine Use

In your entire life, have you had at least 1 drink of any kind of alcohol, not counting small tastes or sips?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

How often do you have a drink containing alcohol?

- ◯ Never
- ◯ Monthly or less
- ◯ 2-4 times a month
- ◯ 2-3 times a week
- ◯ 4 or more times a week
- ◯ Don't know or refuse to answer

Do you now smoke cigarettes?

- ◯ Every Day
- ◯ Some Days
- ◯ Not at all
- ◯ Prefer not to answer
- ◯ Don't know

If you smoke every day, on average, how many cigarettes per day do you smoke?

____

Do you now use electronic cigarettes every day, some days, rarely, or not at all?

- ◯ Every Day
- ◯ Some Days
- ◯ Rarely
- ◯ Not at all
- ◯ Prefer not to answer
- ◯ Don't know

Identity

About you

Date of Identity Collection

____
(MM/DD/YYYY)

First Name

____

Last Name

____

Street Address

____

Street Address 2

____

City

____

State or Territory	◯ Alabama ◯ Alaska ◯ Arizona ◯ Arkansas ◯ California ◯ Colorado ◯ Connecticut ◯ Delaware ◯ District of Columbia(DC) ◯ Florida ◯ Georgia ◯ Hawaii ◯ Idaho ◯ Illinois ◯ Indiana ◯ Iowa ◯ Kansas ◯ Kentucky ◯ Louisiana ◯ Maine ◯ Maryland ◯ Massachusetts ◯ Michigan ◯ Minnesota ◯ Mississippi ◯ Missouri ◯ Montana ◯ Nebraska ◯ Nevada ◯ New Hampshire ◯ New Jersey ◯ New Mexico ◯ New York ◯ North Carolina ◯ North Dakota ◯ Ohio ◯ Oklahoma ◯ Oregon ◯ Pennsylvania ◯ Rhode Island ◯ South Carolina ◯ South Dakota ◯ Tennessee ◯ Texas ◯ Utah ◯ Vermont ◯ Virginia ◯ Washington ◯ West Virginia ◯ Wisconsin ◯ Wyoming ◯ American Somoa ◯ GUAM ◯ Northern Mariana Islands ◯ Puerto Rico ◯ US Virgin Islands
Mobile Phone	______________________
Home Phone	______________________

Other Phone	__________________
Personal Email	__________________
Other Email	__________________
Preferred Method of Contact	◯ Mobile phone ◯ Home phone ◯ Other phone ◯ Personal email ◯ Other email
Date of Birth	__________________ (MM/DD/YYYY)

Tier2 Sociodemographics

Are any of these a closer description of how you think of yourself?	◯ Queer ◯ Polysexual, omnisexual, sapiosexual or pansexual ◯ Asexual or Asexual Spectrum ◯ Two-spirit ◯ Have not figured out or are in the process of figuring out your sexuality ◯ Mostly straight, but sometimes attracted to people of your own sex ◯ Do not think of yourself as having sexuality ◯ Do not use labels to identity yourself ◯ Don't know the answer ◯ No, I have a different description and would like to specify
Specify your description of how you think of yourself	__________________________________

Tier2 Medical History

Missed medical procedure

Since the start of the COVID-19 pandemic (March 2020), have you needed to postpone any medical care?	◯ Yes ◯ No

Tier2 Vaccine Acceptance

Have you completed the COVID-19 vaccination course? Most COVID-19 vaccines require two shots.	◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know

Tier2 Testing

Perceived accuracy of testing

How confident are you that a negative test result means that you do not have COVID-19?

- ◯ Not at all confident
- ◯ Somewhat confident
- ◯ Confident
- ◯ Very confident

How confident are you that a positive test result means that you do have COVID-19?

- ◯ Not at all confident
- ◯ Somewhat confident
- ◯ Confident
- ◯ Very confident

Perceived benefits of testing

How much do the following encourage you to get tested?

	Not at all	Slightly	Somewhat	Moderately	Very much
Reduce worry that I might have COVID-19.	◯	◯	◯	◯	◯
Believe that I was exposed to someone who has COVID-19.	◯	◯	◯	◯	◯
To know if I am safe not to give COVID-19 to friends and family.	◯	◯	◯	◯	◯
To know if I am safe not to give COVID-19 to anyone I am around.	◯	◯	◯	◯	◯
To let my employer know that I am safe to work.	◯	◯	◯	◯	◯
To get treated early (if I am positive).	◯	◯	◯	◯	◯

Perceived risks of testing

How much do the following discourage you to get tested?

	Not at all	Slightly	Somewhat	Moderately	Very much
May experience discomfort from being tested.	◯	◯	◯	◯	◯
Even if I don't have it when tested, I can still get COVID-19 later.	◯	◯	◯	◯	◯
I don't have COVID-19 symptoms so I don't need to be tested.	◯	◯	◯	◯	◯

If I'm positive, officials will need to contact the people I've been in contact with.	◯	◯	◯	◯	◯
I don't want to know if I have it.	◯	◯	◯	◯	◯
Not much they can do for me if I have it.	◯	◯	◯	◯	◯
Difficult to get needed healthcare if I have it.	◯	◯	◯	◯	◯

Intention to be tested

I plan to get tested as often as needed.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither disagree or agree
- ◯ Agree
- ◯ Strongly agree

Interpretation of negative or positive results

If I get a negative test result, it means

[check all that apply]:

- ☐ I don't have to worry about getting COVID-19
- ☐ I don't have COVID-19 now
- ☐ I can be around others without giving the virus to them
- ☐ I can be around others without getting the virus from them

(Check all that apply)

If I get a positive result, it means:

[check all that apply]

- ☐ I will need to be admitted to the hospital
- ☐ I will need to isolate myself from others
- ☐ I will need to take off work

(Check all that apply)

Tier2 Medications

Date of Medication Collection

____
(MM/DD/YYYY)

Medications

The US Food and Drug Administration (FDA) maintains a searchable database of brand name drugs, generic drugs and therapeutic biological products that can assist with classification and action of medications.

Do you currently take prescription medications?
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer or do not remember

Prescription Medication 1

____

Prescription Medication 2

____

Prescription Medication 3

____

Prescription Medication 4

____

Prescription Medication 5

____

Prescription Medication 6

____

Prescription Medication 7

____

Prescription Medication 8

____

Prescription Medication 9

____

Prescription Medication 10

____

Prescription Medication 11

____

Prescription Medication 12

____

Prescription Medication 13

____

Prescription Medication 14

____

Prescription Medication 15

____

Prescription Medication 15

Prescribed medications unable to transcribe: __________________________________

Tier2 Alcohol And Tobacco

How many drinks containing alcohol do you have on a typical day when you are drinking?

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 or 6
- ◯ 7, 8 or 9
- ◯ 10 or more
- ◯ Prefer not to answer

How many years have you smoked?

____

How many years have you vaped?

____

Tier2 Drug Use

Date of Drug Use Collection

____
(MM/DD/YYYY)

Have you used marijuana in the past 12 months?

- ◯ Yes
- ◯ No

If you have used marijuana in the past 12 months, have often have you smoked it?

- ◯ Daily or almost daily
- ◯ About once or twice per week
- ◯ About once per month
- ◯ Rarely (less than once per month)
- ◯ Never
- ◯

If you have used marijuana in the past 12 months, have often have you vaped it?

- ◯ Daily or almost daily
- ◯ About once or twice per week
- ◯ About once per month
- ◯ Rarely (less than once per month)
- ◯ Never
- ◯

In the past 12 months, have often have you used prescription drugs just for the feeling, more than prescribed, or that were not prescribed for you?

- ◯ Daily or almost daily
- ◯ About once or twice per week
- ◯ About once per month
- ◯ Rarely (less than once per month)
- ◯ Never
- ◯

In the past 12 months, have you used any of the following drugs: cocaine or crack, heroin, crystal meth (methamphetamine), hallucinogens (like LSD, psilocybin, PCP, ketamine), ecstasy?

- ◯ Yes
- ◯ No

How often have you used each of the following drugs?

Cocaine or crack

- ◯ Daily or almost daily
- ◯ About once or twice per week
- ◯ About once per month
- ◯ Rarely (less than once per month)
- ◯ Never
- ◯

Heroin

- ◯ Daily or almost daily
- ◯ About once or twice per week
- ◯ About once per month
- ◯ Rarely (less than once per month)
- ◯ Never
- ◯

Crystal meth (methamphetamine)

- ◯ Daily or almost daily
- ◯ About once or twice per week
- ◯ About once per month
- ◯ Rarely (less than once per month)
- ◯ Never
- ◯

Hallucinogens (like LSD, psilocybin, PCP, ketamine)	◯ Daily or almost daily ◯ About once or twice per week ◯ About once per month ◯ Rarely (less than once per month) ◯ Never ◯
Ecstasy	◯ Daily or almost daily ◯ About once or twice per week ◯ About once per month ◯ Rarely (less than once per month) ◯ Never ◯

Tier2 Disability

Date of Disability Collection	____________________ (MM/DD/YYYY)
Are you deaf, or do you have serious difficulty hearing?	◯ Yes ◯ No
Are you blind, or do you have serious difficulty seeing, even when wearing glasses?	◯ Yes ◯ No
Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years of age or older)	◯ Yes ◯ No
Do you have serious difficulty walking or climbing stairs? (5 years of age or older)	◯ Yes ◯ No
Do you have difficulty dressing or bathing? (5 years of age or older)	◯ Yes ◯ No
Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years of age or older)	◯ Yes ◯ No

Tier2 Food Insecurity

Food Insecurity:

I'm going to read you two statements that people have made about their food situation.

Please tell me whether the statement was OFTEN, SOMETIMES, or NEVER true for (you/you and the other members of your household) in the last 12 months.

Question	Options
The first statement is, "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?	◯ Often true ◯ Sometimes true ◯ Never true ◯ Don't know ◯ Prefer not to answer
The second statement is, "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?	◯ Often true ◯ Sometimes true ◯ Never true ◯ Don't know ◯ Prefer not to answer
In the last 12 months, since (date 12 months ago) did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How often did this happen - almost every month, some months but not every month, or in only 1 or 2 months?	◯ Almost every month ◯ Some months but not every month ◯ Only 1 or 2 months ◯ Don't know ◯ Prefer not to answer
In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
The fresh fruits and vegetables in my neighborhood are of high quality	◯ Completely agree ◯ Somewhat agree ◯ Neutral/no opinion ◯ Somewhat disagree ◯ Strongly disagree ◯ Don't know

Tier2 Housing

In the past two months, have you been staying in the same place?	◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know
Are you worried or concerned that in the next two months you may NOT have a place to stay?	◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know

Tier2 Trust

How much do you trust each of these sources to provide correct information about COVID 19? (Select one response for each row.)

	Not at all	A little	Somewhat	A great deal	Don't know
Your doctor or health care provider	○	○	○	○	○
Your faith leader	○	○	○	○	○
Your close friends and members of your family	○	○	○	○	○
People you go to work or class with or other people you know	○	○	○	○	○
News on the radio, TV, online, or in newspapers	○	○	○	○	○
Your contacts on social media	○	○	○	○	○
The U.S. government	○	○	○	○	○
The U.S. Coronavirus Task Force	○	○	○	○	○

Tier2 Ssn And Mrn

Social Security Number ________________________________

Medical Record Number ________________________________

Medical Record Number Organziation ________________________________