ORCHARDS HOUSEHOLD STUDY FORM

PARTICIPANT LABEL

ID

Gender: Female Male Non-Binary

Race: White American Indian or Alaskan Native
Asian Black Native Hawaiian or Other Pacific Islander

Ethnicity: Hispanic Non-Hispanic

Do you work outside the home? Yes (in person) No Remote/Virtual

NASAL SWAB

Do you attend school? Yes (in person) No Homeschool/Virtual

Number of bedrooms in household:_____ **Do you attend Daycare?** Yes No

Did you receive an influenza vaccine this year (after August 1, 2022)? Yes No

Have you received a COVID-19 vaccine? (if yes, please select type(s) and number of doses if known)**:**

Yes *Moderna / Pfizer / Johnson & Johnson* Not Vaccinated
1st Dose □ 2nd Dose □ Booster □ Additional Booster(s) □

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TODAY Day 0

Have you been tested for COVID-19 in the past 14 Days? Yes (**test date** and **result** if known)_____ No

Recent Travel? Yes (please list **dates** and **location**)_____ No

Have you had cold or flu-like symptoms in the past 14 days? Yes No (if **No**, stop here)

If yes: How many days ago did your symptoms start? _____

Exposure to a similar illness 1-14 days prior to illness onset? Yes No

Likely Source: Classmate Friend Family Member (Adult/Child) Co-Worker Other: _____

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 14 days? (circle all that have been present)

Fever	Chills	Cough	Wheezing	Runny Nose	Sore Throat
Fatigue	Muscle Pain	Joint Pain	Headache	Stuffy Nose	Ear Pain
No Appetite	Vomiting	Abdominal Pain	Diarrhea	Conjunctivitis	Shortness of Breath
Loss of smell	Loss of taste	Other: _____			

Were you seen by a healthcare provider? Yes No **Where?** Virtual Visit Usual Clinic Urgent Care ER

What diagnosis were your given? _____

Were you given an antibiotic or antiviral medication? Yes (type if known) _____ No

Were you sent to the hospital for this illness? Yes No

Did you miss school or work in the past 7 days due to illness? Yes (list number of days missed) _____ No

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NASAL SWAB

TODAY Day 7

Recent Travel? Yes (please list **dates** and **location**) _____ No

Have you had cold or flu-like symptoms in the past 7 days? Yes No (if **No**, stop here)

If yes:

Are these continuing symptoms from ☐ Day 0
OR
☐ New symptoms (please list **start date**) _____

Are you <u>currently</u> experiencing symptoms? Yes No (if **No**, list symptom **end date**) _____

Exposure to a similar illness 1-14 days prior to illness onset? Yes No

Likely Source: Classmate Friend Family Member (Adult/Child) Co-Worker Other: _____

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 7 days? (circle all that have been present)

Fever	Chills	Cough	Wheezing	Runny Nose	Sore Throat
Fatigue	Muscle Pain	Joint Pain	Headache	Stuffy Nose	Ear Pain
No Appetite	Vomiting	Abdominal Pain	Diarrhea	Conjunctivitis	Shortness of Breath
Loss of smell	Loss of taste	Other: _____			

Were you seen by a healthcare provider? Yes No **Where?** Virtual visit Usual Clinic Urgent Care ER

What diagnosis were your given? _____

Were you given an antibiotic or antiviral medication? Yes No _____

Were you sent to the hospital? Yes No

Did you miss school or work in the past 7 days? Yes No **If yes, how many days did you miss?** _____

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NASAL SWAB

Over the past 2 weeks, have you:

Used a face mask/covering outside of your home (when social distancing is not possible)?

Never Rarely Sometimes Often Always

Practiced social/physical distancing when outside of your home?

Never Rarely Sometimes Often Always

- -

TODAY Day 14

Recent Travel? Yes (please list **dates** and **location**) ______________________________ No

Have you had cold or flu-like symptoms in the past 7 days? Yes No (if **No**, stop here)

If yes:

Are these continuing symptoms from

- ☐ Day 0
- ☐ Day 7
- ☐ Neither/new symptoms (please list **start date**) ________________

Are you <u>currently</u> experiencing symptoms? Yes No (if **no**, list symptom **end date**) ________________

Exposure to a similar illness 1-14 days prior to illness onset? Yes No

Likely Source: Classmate Friend Family Member (Adult/Child) Co-Worker Other: _________

How severe are/were your symptoms? Mild Moderate Severe

What symptoms have you had in the past 7 days? (circle all that have been present)

Fever	Chills	Cough	Wheezing	Runny Nose	Sore Throat
Fatigue	Muscle Pain	Joint Pain	Headache	Stuffy Nose	Ear Pain
No Appetite	Vomiting	Abdominal Pain	Diarrhea	Conjunctivitis	Shortness of Breath
Loss of smell	Loss of taste	Other: _____________________________________			

Were you seen by a healthcare provider? Yes No **Where?** Virtual visit Usual Clinic Urgent Care ER

What diagnosis were your given? _______________________

Were you given an antibiotic or antiviral medication? Yes No _________________________

Were you sent to the hospital? Yes No

Did you miss school or work in the past 7 days? Yes No **If yes, how many days did you miss?** _____