Do you have cold or flu-like symptoms in the past 14 days? Yes  No  

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
Do you attend school? Yes (in person)  No  Homeschool/Virtual
Number of bedrooms in household:  

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)  □

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 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
ORCHARDS HOUSEHOLD STUDY FORM

Gender: Female       Male       Non-Binary

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

Ethnicity: Hispanic        Non-Hispanic

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 currently 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? _____
ORCHARDS HOUSEHOLD STUDY FORM

Gender: Female  Male  Non-Binary

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

Ethnicity: Hispanic  Non-Hispanic

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

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 currently 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? _____