For all questions related to timing, the COVID-19 pandemic refers to on or after 1 DEC 2019.
Questions listed in red are considered optional.

SECTION A: GENERAL INFORMATION

1. COVID-19 Data Collection ID: ___ ___ ___ ___ - ___ ___ ___ - ___

SECTION B: COVID-LIKE ILLNESS SYMPTOMS AND EXPOSURE

Did you experience any of the following symptoms since our last contact?

	COVID-19 Symptoms/Exposure	Present
1.	Fevers or chills?	☐ YES ☐NO ☐ UNK If yes, maximal temperature you remember: _____ °F or _____°C
2.	New or Worsening Cough a. Dry b. Productive	☐ YES ☐NO ☐ UNK ☐ YES ☐NO ☐ UNK
3.	If Yes to cough, indicate Frequency: a. Occasional, several per hour or less b. Constant (every 15 minutes or greater)	☐ YES ☐NO ☐ UNK ☐ YES ☐NO ☐ UNK
4.	New or worsened shortness of breath	☐ YES ☐NO ☐ UNK
5.	Diarrhea	☐ YES ☐NO ☐ UNK
6.	Altered or reduced sense of smell or taste	☐ YES ☐NO ☐ UNK
7.	Muscle aches/Severe fatigue	☐ YES ☐NO ☐ UNK
8..	Chest pain or tightness	☐ YES ☐NO ☐ UNK
9.	Sore throat	☐ YES ☐NO ☐ UNK
10.	Nausea or vomiting	☐ YES ☐NO ☐ UNK
11.	Approximately when did your symptoms begin?	DD-MMM-YYYY
12.	Have you been exposed to anyone with known or suspected COVID-19?	☐ YES ☐NO ☐ UNK
13.	Have you used public transportation during the COVID-19 pandemic (plane, bus, train, Taxi/Uber/Lyft etc)?	☐ YES ☐NO ☐ UNK

SECTION C: COVID-LIKE ILLNESS TESTING AND TREATMENT			
	Testing and Treatment	**Present**	**DESCRIPTION**
1.	Have you been tested for COVID-19? (test with a swab in the nose)	☐ YES ☐NO ☐ UNK	If yes, which month: _____
2.	*If yes to #1*,Have you been told that you have tested positive for COVID-19?	☐ YES ☐NO ☐ UNK	
3.	Have you been told that you might have had COVID-19/have symptoms suggestive of COVID-19?	☐ YES ☐NO ☐ UNK	
4.	Have you been tested for prior COVID-19 exposure or infection (presence of antibodies in your blood)?"	☐ YES ☐NO ☐ UNK	If yes, which month: _____
5.	Have you been told that you have antibodies in your blood that suggest you were previously exposed COVID-19 infection? (test with a blood sample with a skin prick or needle)	☐ YES ☐NO ☐ UNK	

SECTION D: MEDICATION USE DURING COVID-19 PANDEMIC			
	Medication Use		
1.	Are you currently prescribed an ACEI/ARB/ARNI? (list drug names here) *If no or unknown* to #1, skip to #3.	☐ YES ☐NO ☐ UNK	If yes, which one? ☐ ACEI (captopril, lisinopril, enalapril, fosinopril) ☐ ARB (valsartan, losartan, candesartan) ☐ ARNI (sacubitril/valsartan) ☐ Unknown
2.	Did you stop taking your ACEI/ARB/ARNI at any time during COVID-19 pandemic?	☐ YES ☐NO ☐ UNK	If yes, why? ☐ Instructed by my doctor ☐ Self-discontinued ☐ Unknown/other
3.	Are you currently/have you taken a NSAID (naproxen, ibuprofen, celecoxib) during the COVID-19 pandemic? *If no or unknown* to #3, skip to #5.	☐ YES ☐NO ☐ UNK	
4.	Did you stop taking your NSAIDS (naproxen, ibuprofen, celecoxib) at any time during the COVID-19 pandemic?	☐ YES ☐NO ☐ UNK	If yes, why? ☐ Instructed by my doctor ☐ Self-discontinued ☐ Unknown/other
5.	Do you/have you newly started chloroquine/hydroxychloroquine during the COVID-19 pandemic?	☐ YES ☐NO ☐ UNK	

SECTION E: EFFECTS OF COVID PANDEMIC ON YOU			
1.	Have you had a direct **in-person** contact with a medical professional during the COVID-19 pandemic?	☐ YES ☐NO ☐ UNK	If yes, whom (check all that apply)? ☐ Family member/Friend ☐ Rehab/nursing facility Staff ☐ Homecare/Visiting Nurse ☐ Doctor/Nurse Practitioner/Physician Assistant ☐ Emergency Department/Hospital Staff ☐ Unknown
2.	Have you had an **in-person** appointment during the COVID-19 pandemic?	☐ Yes ☐ No ☐ Unknown	If yes, what kind of appointment? (check all that apply) ☐ Primary Care ☐ Cardiology/HF related ☐ Other/Unknown
3.	Have you felt the need to go to an emergency department or hospital but decided not to because of concerns about COVID-19?	☐ Yes ☐ No ☐ Unknown	
4.	Have you participated in a telehealth visit during COVID-19 pandemic?	☐ Yes, how many? _____ ☐ No ☐ Unknown	Overall satisfaction with telehealth visit(s): ☐ 1 Very unsatisfied ☐ 2 Somewhat unsatisfied ☐ 3 Neutral ☐ 4 Somewhat satisfied ☐ 5 Very satisfied
5.	*If yes to #4:* Was this the first time you have participated in a telehealth visit?	☐ YES ☐NO ☐ UNK	If yes, would you be interested in participating in telehealth visits for your medical care after the COVID-19 pandemic? ☐ YES ☐NO ☐ UNK
6.	*If yes to #4:* What form of technology did you use for your telehealth visit (check all that apply)	☐ Telephone Visit ☐ Face to face Video Conference (Zoom, Facetime) ☐ Other	
7.	Have you had an appointment cancelled/rescheduled due to COVID-19 pandemic?	☐ Yes, how many? _____ ☐ No ☐ Unknown	If yes, what kind of appointment? (check all that apply) ☐ Primary Care ☐ Cardiology/HF related ☐ Other/Unknown

8.	Have you had a procedure cancelled/rescheduled due to COVID-19 pandemic?	☐ YES ☐NO ☐ UNK	If yes, type of procedure ☐ Cardiology procedure ☐ Other procedure
9.	How has COVID-19 pandemic affected your job? (check all that apply)	☐ No change/remained employed ☐ Transitioned to work from home ☐ Job furloughed/lapse in employment ☐ Had a job loss/layoff ☐ Remained unemployed ☐ Remained retired ☐ Prefer not to disclose	
10.	How has your activity/exercise level changed during COVID-19 pandemic?	☐ No change ☐ More activity/exercise ☐ Less activity/exercise	
11.	Do you smoke?	☐ YES ☐NO ☐ UNK	If yes, how has your average smoking amount changed due to COVID-19 pandemic? ☐ No change, ___ ppd ☐ More smoking, ___ ppd to ___ ppd ☐ Less smoking, ___ ppd to ___ ppd
12.	Do you drink alcohol?	☐ YES ☐NO ☐ UNK	If yes, how has your average alcohol intake amount changed due to COVID-19 pandemic? ☐ No change ☐ More drinking ☐ Less drinking

SECTION F: ADDITIONAL PATIENT-SPECIFIC QUESTIONS			
		Present	**DESCRIPTION**
1.	Do you know someone in your immediate family who has had COVID-19?	☐ YES ☐NO ☐ UNK	
2.	Do you know someone in your extended family/friends who has had COVID-19?	☐ YES ☐NO ☐ UNK	
3.	Do you know someone who has died from COVID-19?	☐ YES ☐NO ☐ UNK	
4.	Do you plan to get a vaccine for COVID-19 when available?	☐ YES ☐ NO ☐ UNK	If NO, why? ☐ Do not think I need it ☐ Do not think it will work ☐ Think it may give me COVID ☐Other _____
5.	Do you know someone who has died from influenza or "the flu"?	☐ YES ☐NO ☐ UNK	
6.	Did you or do you plan to get the "flu" or influenza shot/vaccine this season?	☐ YES ☐ NO, but plan to ☐ NO and do not plan to ☐ UNK	If YES, which month: _____ If NO and don't plan to, why? ☐ Do not think I need it ☐ Do not think it will work ☐ Think it may give me flu ☐Other _____
7.	What is your preferred way to have an appointment with your doctor	☐ In person, face-to-face ☐ Telehealth, by telephone ☐ Telehealth, by video chat ☐ UNK	If telehealth, why? ☐Do not have to sit in waiting room ☐Do not have to drive/park ☐More time with doctor ☐Other _____

SECTION G: SOCIOECONOMIC FACTORS			
1.	Description of place of primary residence	☐ Single Family Home ☐ Multi-unit building/ complex ☐ Assisted living ☐ Rehab/long term care/nursing facility ☐ Transient Housing/Shelter ☐ Other	If not in a single-family home, approx. number of units living in the **building/complex**: _____
2.	Number of people in your Household:	Children under 18: _____ Adult 18-65: _____ Elderly 65+:: _____	
3.	What is the highest form of education you have?	☐ None ☐ High School Degree ☐ College Degree ☐ Graduate Degree ☐ Unknown/Prefer not to say	
4.	Are you a healthcare worker or do you work at a place that provides direct medical care to patients?	☐ YES ☐NO ☐ UNK	
5.	Are you working at a place with direct contact with others (grocery, retail, delivery, etc.)?	☐ YES ☐NO ☐ UNK	
6.	Did your place of work offer a work-from-home option during COVID-19 pandemic?	☐ YES ☐NO ☐ UNK	If yes, what approx. date did you start working from home? _____

SECTION H: HOSPITALIZATIONS			
Since our last contact, have you been hospitalized for any reason? ☐ YES ☐ NO			
	HOSPITALIZATION DETAILS		
1.	Location: City_____ , State _____	Diagnosis:	Primary Admitting Service: ☐ Cardiology ☐ Medicine ☐ ICU ☐ Specialized COVID-19 unit ☐ Other
2.	Date of Admission:	Length of stay (days): ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ >10	
4.	Did you require a stay in the intensive care unit?	☐ YES ☐ NO ☐ UNK	
5.	Did you need supplemental oxygen by a nasal cannula or mask (CPAP machine, facemask) without the need for a breathing tube?	☐ YES ☐ NO ☐ UNK	
6.	Did you need a breathing tube/intubation?	☐ YES ☐ NO ☐ UNK	
7.	To where were you discharged?	☐ Home ☐ Rehab/nursing facility ☐ Hospice ☐ Other: _____	

SECTION I: CONTINUED COVID-19 RESEARCH PARTICIPATION			
1.	Would you be willing to have a blood test added to your upcoming bloodwork to test for whether you have previously had the COVID-19 infection?	☐ YES ☐ NO ☐ UNK	
2.	Would you be willing to participate in further research to help understand the impact of COVID-19 on your health?	☐ YES ☐ NO ☐ UNK	If yes, would you be willing to answer questions/surveys in the following formats (check all that apply): ☐ Paper ☐ Telephone Call ☐ Electronic/Website ☐ Smartphone/tablet app ☐ Unknown/other