COVID-19 Questionnaire

CanPath
Canadian Partnership for Tomorrow's Health
Partenariat canadien pour la santé de demain

Participating Cohorts

Atlantic PATH
PARTNERSHIP FOR TOMORROW'S HEALTH
For the Benefit of Future Generations

BC GENERATIONS PROJECT
Your time today builds a healthier tomorrow.

CARTaGENE

CancerCare Manitoba
ActionCancerManitoba
THE MANITOBA TOMORROW PROJECT

Ontario Health Study
Étude sur la santé Ontario

The Tomorrow Project
Albertans for a Healthier Future

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DIRECTIONS FOR COMPLETING THIS QUESTIONNAIRE

Thank you for participating in this questionnaire! As the recent COVID-19 pandemic continues to affect all of our lives, we are seeking your help to better understand and track the disease.

You will have **TWO WEEKS** to complete this questionnaire. You do not need to finish this questionnaire all at once. You may pause, save your progress and return to it at a later time.

This questionnaire is designed to assess the impact that COVID-19 may have had on your health, both physical and mental, to ask about the known risk factors for COVID-19, and to learn about how the pandemic affected other parts of your life, such as your social support network and employment status.

Even if you have NOT experienced COVID-19 symptoms, please take the questionnaire - your answers are still valuable to health researchers.

Please enter a response to each question on the screen. If there are questions you do not feel comfortable answering, please select the "Prefer not to answer" option where applicable.

DEMOGRAPHIC INFORMATION

DE01. How old are you?
Note: to register your answers after you've typed them, simply click somewhere else on the page.
_____ years

DE02. What was your sex at birth?
|_| Male
|_| Female

The next few questions ask about sex and gender. Both biological and social differences between women and men contribute to differences in their health. Sex (biological attributes) and gender (socio-cultural factors) can influence things like our risk of developing certain diseases, response to medical treatments, and how often we seek health care.

DE03. Which best describes your current gender identity?
|_| Male
|_| Female
|_| Indigenous or other cultural gender minority (e.g., two-spirit)
|_| Other (e.g., gender fluid, non-binary)
|_| Prefer not to answer

DE04. What gender do you currently live as in your day-to-day life?
|_| Male
|_| Female
|_| Sometimes male, sometimes female
|_| Something other than male or female
|_| Prefer not to answer

DE05. [IF DE02 = Female] Are you currently pregnant?
|_| Yes
|_| No → Skip to DE07
|_| Don't know → Skip to DE07

DE06. [IF DG05 = Yes] In what week are you?
_____weeks

DE07. How many adults (age 18 or older) and children (under 18 years of age) including yourself are currently living in your household?
|_| I live alone
|_| Number of children under 18 years old? ___
|_| Number of adults 18 to 59 years old? ___
|_| Number of adults 60 to 69 years old? ___
|_| Number of adults 70 to 79 years old? ___

|_| Number of adults 80 years old or more? ___
|_| Don’t know

DE08. What type of dwelling do you currently live in?
|_| House (e.g., single detached, semi-detached, duplex or townhouse)
|_| Apartment or condominium
|_| Seniors’ housing (e.g., retirement home, senior lodges, senior residences, assisted living)
|_| Institution (e.g., long-term care facility, nursing home)
|_| Other (e.g. mobile home, hotel, rooming house, or group home)
|_| Prefer not to answer
|_| Don’t know

DE09. [FOR ALBERTA’S TOMORROW PROJECT, BC GENERATIONS PROJECT, AND CARTAGENE ONLY] What is your current residential Postal Code?
Postal Code:_____
|_| I live outside of Canada
|_| Prefer not to answer
|_| Don’t know

DE09. [FOR ATLANTIC PATH, ONTARIO HEALTH STUDY, AND THE MANITOBA TOMORROW PROJECT ONLY] What are the first three digits of your current residential Postal Code?
Note: The response format should be similar to “M1M”.
First three digits of postal code:_____
|_| I live outside of Canada
|_| Prefer not to answer
|_| Don’t know

COVID-19 DIAGNOSES

DG01. Have you used an online screening or self-assessment tool to determine if you might have and/or should be tested for COVID-19?
|_| Yes
|_| No → Skip to DG03
|_| Prefer not to answer → Skip to DG03

DG02. [IF DG01 = Yes] What was the source of the self-assessment tool?
Select all that apply:
|_| Provincial health authority or government
|_| Employer
|_| Other
|_| Don't know

DG03. As of today, have you been tested for COVID-19?
|_| Yes
|_| No – because I haven't experienced any symptoms → Skip to DG08
|_| No – I have experienced one or more symptoms (for example, a cough, mild fever, muscle soreness, fatigue) but have not been tested → Skip to DG07
|_| No – I have experienced symptoms but I do/did not meet the testing criteria in my province → Skip to DG07
|_| Prefer not to answer → Skip to DG08

DG04. [IF DG03 = Yes] What was the result of your COVID-19 test?
|_| Negative
|_| Positive
|_| Prefer not to answer
|_| Don't know or have not received results yet

DG05. [IF DG03 = Yes] What was the date of your COVID-19 test?
_____ (DD-MM-YYYY)
|_| Prefer not to answer
|_| Don't know

DG06. [IF DG04 = Negative OR Positive OR Prefer not to answer] What was the date that you received the results?
Note: The date entered must be later than or the same as the date of your COVID-19 test.
_____ (DD-MM-YYYY)
|_| Prefer not to answer
|_| Don't know

DG07. [IF DG03 = No – I have experienced one or more symptoms (for example, a cough, mild fever, muscle soreness, fatigue) but have not been tested OR No – I

have experienced symptoms but I do/did not meet the testing criteria in my province] Do you suspect you have/had an undiagnosed case of COVID-19?
|_| Yes
|_| No
|_| Don't know

DG08. Did you receive treatment with any experimental therapies for COVID-19 for prevention or treatment?
|_| Yes
|_| No → Skip to SY01
|_| Prefer not to answer → Skip to SY01
|_| Don't know → Skip to SY01

DG09. [IF DG08 = Yes] Which experimental therapies did you receive?
Select all that apply:
|_| Remdesivir
|_| Chloroquine/Hydroxychloroquine
|_| Lopinavir-Ritonavir
|_| Tocilizumab
|_| Colchicine
|_| Other – please specify:_____
|_| Prefer not to answer
|_| Don't know

DG10. [IF DG08 = Yes] Were the therapies described above prescribed to you by a clinician for COVID-19?
|_| Yes
|_| No
|_| Prefer not to answer
|_| Don't know

COVID-19 SYMPTOMS

*We are interested in whether you've experienced flu-like and other symptoms, which may be related to COVID-19. For these next questions, please consider any symptoms which are **not** due to other health issues you might usually experience/expect, such as seasonal allergies, existing medical conditions, etc.*

SY01. Have you had a fever since January 1, 2020?
|_| Yes
|_| No → Skip to SY04
|_| Don't know → Skip to SY04

SY02. [IF SY01 = Yes] How long did it last (if you had more than one fever answer this question for the longest)?
Hours:_____
Or Days:_____
|_| Don't know

SY03. [IF SY01 = Yes] What was the highest temperature recorded?
_____°C
_____°F
|_| I did not take my temperature
|_| Don't know

SY04. Since January 1, 2020, have you experienced any of the following symptoms?
Please do not include symptoms related to factors you might usually experience/expect, such as seasonal allergies, asthma, COPD, or other existing medical conditions. Please be sure to respond to all the questions. Select 'No' for a question if it doesn't apply to you, or 'Don't know' if you are not sure.

	No	Mild	Severe	Don't know
Dry cough	|_|	|_|	|_|	|_|
Wet cough (cough that produces mucus)	|_|	|_|	|_|	|_|
Runny nose	|_|	|_|	|_|	|_|
Sinus pain	|_|	|_|	|_|	|_|
Ear pain	|_|	|_|	|_|	|_|
Sore throat	|_|	|_|	|_|	|_|
Hoarseness	|_|	|_|	|_|	|_|
Shortness of breath or difficulty breathing	|_|	|_|	|_|	|_|
Headache	|_|	|_|	|_|	|_|

	No	Mild	Severe	Don't know
Fatigue	|_|	|_|	|_|	|_|
General muscle and/or joint aches and pains	|_|	|_|	|_|	|_|
Chills or shivering	|_|	|_|	|_|	|_|
Loss of taste	|_|	|_|	|_|	|_|
Loss of sense of smell	|_|	|_|	|_|	|_|
Diarrhea	|_|	|_|	|_|	|_|
Loss of appetite	|_|	|_|	|_|	|_|
Nausea	|_|	|_|	|_|	|_|
Vomiting	|_|	|_|	|_|	|_|

SY05. Did you experience any other symptoms?
|_| Yes – please specify:_____
|_| No other symptoms → Skip to SY07

SY06. [IF SY05 = Yes] How severe were these symptoms?
|_| Mild
|_| Severe
|_| Don't know

SY07. [IF SY01 = Yes; IF SY04 = Mild OR Severe FOR ANY SYMPTOM; IF SY05 = Yes] When did you first experience these symptoms?
If you don't remember the exact date, please provide the best estimate that you can.
_____(DD-MM-YYYY)
|_| Don't know

SY08. [IF SY01 = Yes; IF SY04 = Mild OR Severe FOR ANY SYMPTOM; IF SY05 = Yes] Do you feel back to normal?
|_| Completely
|_| Mostly
|_| A bit → Skip to SY10
|_| Not really → Skip to SY10
|_| Not at all → Skip to SY10

SY09. [IF SY08 = Completely OR Mostly] If you feel back to normal, how long were you sick for?
Number of days:_____
|_| Don't know

SY10.

	No	Mild	Severe	Don't know
[IF SY01 = Yes] Do you still have difficulty with a fever?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Dry cough] Do you still have difficulty with a dry cough?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Wet cough (cough that produces mucus)] Do you still have difficulty with a wet cough (cough that produces mucus)?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Runny nose] Do you still have difficulty with a runny nose?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Sinus pain] Do you still have difficulty with sinus pain?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Ear pain] Do you still have difficulty with ear pain?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Sore throat] Do you still have difficulty with a sore throat?	|_|	|_|	|_|	|_|

	No	Mild	Severe	Don't know
[IF SY04 = Mild OR Severe FOR Hoarseness] Do you still have difficulty with hoarseness?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Shortness of breath or difficulty breathing] Do you still have difficulty with shortness of breath or difficulty breathing?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Headache] Do you still have difficulty with headaches?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Fatigue] Do you still have difficulty with fatigue?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR General muscle and/or joint aches and pains] Do you still have difficulty with general muscle and/or joint aches and pains?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Chills or shivering] Do you still have difficulty with chills or shivering?	|_|	|_|	|_|	|_|

	No	Mild	Severe	Don’t know
[IF SY04 = Mild OR Severe FOR Loss of taste] Do you still have difficulty with loss of taste?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Loss of sense of smell] Do you still have difficulty with loss of sense of smell?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Diarrhea] Do you still have difficulty with diarrhea?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Loss of appetite] Do you still have difficulty with loss of appetite?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Nausea] Do you still have difficulty with nausea?	|_|	|_|	|_|	|_|
[IF SY04 = Mild OR Severe FOR Vomiting] Do you still have difficulty with vomiting?	|_|	|_|	|_|	|_|

SY11. [IF SY01 = Yes; IF SY04 = Mild OR Severe FOR ANY SYMPTOM; IF SY05 = Yes] While you were experiencing COVID-19 related symptoms, did you have close contact with any of the following? Close contact means physical contact such as hugging, kissing, shaking hands, etc. Please be sure to respond to all the questions. Select ‘No’ for a question if it doesn’t apply to you, or 'Don’t know' if you are not sure.

	Yes	No	Don’t know
Spouse or partner	|_|	|_|	|_|

		→ Skip to CH01	→ Skip to CH01
Family members living in the same place	|_|	|_| → Skip to CH01	|_| → Skip to CH01
Family members living in another place	|_|	|_| → Skip to CH01	|_| → Skip to CH01
Housemates	|_|	|_| → Skip to CH01	|_| → Skip to CH01
Friends	|_|	|_| → Skip to CH01	|_| → Skip to CH01
Work colleagues	|_|	|_| → Skip to CH01	|_| → Skip to CH01

SY12. [IF SY11 = Yes] Has any of those person(s) developed COVID-related symptoms?
|_|Yes
|_|No → Skip to CH01
|_|Don't know → Skip to CH01

SY13. [IF SY12 = Yes] For those person(s) that developed COVID-related symptoms, which category/categories did they belong to and how many individuals were affected?
Select all that apply:
|_| Spouse or partner
|_| Family members living in the same place - number of individuals:_____
|_| Family members living in another place - number of individuals:_____
|_| Housemates - number of individuals:_____
|_| Friends - number of individuals:_____
|_| Work colleagues - number of individuals:_____

COVID-19 - CARE/HOSPITAL RELATED INFORMATION

[FOR PARTICIPANTS WITH A POSITIVE TEST RESULT FOR COVID-19]

CH01. Were you hospitalized because of COVID-19?
|_| Yes
|_| No → Skip to EX01
|_| Don't know → Skip to EX01

CH02. [IF CH01 = Yes] What date did you get admitted to the hospital?
_____(DD-MM-YYYY)
|_| Don't know

CH03. [IF CH01 = Yes] How many days were you in the hospital?
Number of days:_____
|_| Don't know

CH04. [IF CH01 = Yes] Were you admitted to an intensive care unit?
|_| Yes
|_| No → Skip to CH06
|_| Don’t know → Skip to CH06

CH05. [IF CH04 = Yes] How long did you stay in the intensive care unit?
Note: This response must be less than or equal to the number of days spent in the hospital. Your response will register when the ‘Next Page’ button is clicked. Respond to all questions on this page before clicking ‘Next Page’.
Number of days:_____
|_| Don’t know

CH06. [IF CH01 = Yes] Did you have a chest X-ray or CT scan?
|_| Yes
|_| No
|_| Don’t know

CH07. [IF CH01 = Yes] Did you require mechanical ventilation for Covid-19?
|_| Yes
|_| No → Skip to CH09
|_| Don’t know → Skip to CH09

CH08. [IF CH07 = Yes] How many days did you receive mechanical ventilation?
Note: This response must be less than or equal to the number of days spent in the hospital. Your response will register when the ‘Next Page’ button is clicked. Respond to all questions on this page before clicking ‘Next Page’.

Number of days:_____
|_| Don’t know

CH09. [IF CH01 = Yes] What was the reason for ending hospitalization?
|_| Discharge (recovered)
|_| Other/Unknown

CH10. [IF CH01 = Yes] Have you experienced complications related to hospitalization after you were discharged?
|_| Yes
|_| No → Skip to EX01
|_| Don’t know → Skip to EX01

CH11. [IF CH10 = Yes] Did you require further treatment or hospitalization?
|_| Yes
|_| No
|_| Don’t know

COVID-19 – EXPOSURE

EX01. Did you travel after January 1, 2020 (including within and outside your province)?
If you travelled after January 1, 2020 how far did you travel? (Check all that apply in the questions that follow - if you had multiple trips, please list details for your most recent trip for domestic and/or international travel, if applicable).
|_| Yes
|_| No → Skip to EX03
|_| Don't know → Skip to EX03

EX02. [IF EX01 = Yes]
|_| Domestic (within province)

|_| Domestic (outside of province but within Canada)

[IF EX02 = Domestic (outside of province but within Canada)] What city did you travel to for your most recent domestic trip?

_____

[IF EX02 = Domestic (outside of province but within Canada)] What was the start date for your most recent domestic trip?
_____(DD MM YYYY)
|_| Don't know

[IF EX02 = Domestic (outside of province but within Canada)] What was the end date for your most recent domestic trip?
Note: The date entered must be later than or the same as the travel start date.
_____(DD MM YYYY)
|_| Don't know

|_| International

[IF EX02 = International] What countries did you travel to for your most recent international trip?

_____

[IF EX02 = International] What was the start date for your most recent international trip?
_____(DD MM YYYY)
|_| Don't know

[IF EX02 = International] What was the end date for your most recent international trip?

Note: The date entered must be later than or the same as the travel start date.
_____(DD MM YYYY)
|_| Don't know

|_| Travel on a cruise ship

[IF EX02 = Travel on a cruise ship] What was the start date for this cruise?
_____(DD MM YYYY)
|_| Don't know

[IF EX02 = Travel on a cruise ship] What was the end date for this cruise?
Note: The date entered must be later than or the same as the travel start date.
_____(DD MM YYYY)
|_| Don't know

EX03. We're interested in whether other people may have exposed you to COVID-19. To your knowledge, have you been in the same room as a person who was told by a physician that they have COVID-19?
|_| Yes
|_| No → Skip to EX06
|_| Don't Know → Skip to EX06

EX04. [IF EX03 = Yes] On which date did you have first contact with this person after they were diagnosed with COVID-19?
_____(DD MM YYYY)
|_| Don't know

EX05. [If EX03 = Yes] Who was this person with COVID-19?
|_| Spouse or partner
|_| Family member living in the same place
|_| Family member living in another place
|_| Housemate
|_| Friend
|_| Work colleague
|_| Other – please specify:_____

EX06. To your knowledge, since January 1, 2020 have you been in the same room as a person who went on to develop symptoms of COVID-19? These include fever, severe fatigue, shortness of breath, dry cough, muscle pain or increased phlegm production.
|_| Yes

|_| No → Skip to EX09
|_| Don't Know → Skip to EX09

EX07. [IF EX06 = Yes] On which date did you have first contact with this person before they started experiencing symptoms of COVID-19?
_____(DD MM YYYY)
|_| Don't know

EX08. [IF EX06 = Yes] Who was this person with symptoms of COVID-19?
|_| Spouse or partner
|_| Family member living in the same place
|_| Family member living in another place
|_| Housemate
|_| Friend
|_| Work colleague
|_| Other – please specify:_____

EX09. To your knowledge, have you been in the same room as someone who returned from an international trip after January 1st, 2020? If you have travelled internationally since January 1, 2020, do not include people that you travelled with.
|_| Yes
|_| No → Skip to EX11
|_| Don't Know → Skip to EX11

EX10. [IF EX09 = Yes] On which date did you have first contact with this person after they returned from their trip?
_____(DD MM YYYY)
|_| Don't know

EX11. Have you been in any large public gatherings of greater than 250 people (such as a concert) since January 1st 2020?
|_| Yes
|_| No
|_| Don't know

The provinces declared COVID-19 a public health emergency in March 2020, and put recommended prevention measures in place, including restrictions on activities outside the home, physical distancing, and public gatherings to reduce the risk of exposure to COVID-19.

EX12. Since March 2020, which of the following measures did you undertake? ***Select all that apply, even if there are some that you no longer practice due to changing public health guidelines.***
|_| Worked from home, where that was an option for your job
|_| Stocked up on essentials at a grocery store or pharmacy

|_| Avoided leaving the house for non-essential reasons
|_| Used social distancing when out in public (i.e. made changes in your everyday routine to minimize close contact with others)
|_| Avoided crowds and large gatherings
|_| Did not visit with people outside my household
|_| Wore a mask when going out in public
|_| Wore gloves when going out in public
|_| Washed your hands more regularly
|_| Avoided touching your face
|_| Cancelled travel
|_| Other – please specify:_____
|_| None

EX13. Did you regularly take public transit before March 2020?
|_| Yes
|_| No → Skip to EX15
|_| Prefer not to answer → Skip to EX15
|_| Don't Know → Skip to EX15

EX14. [IF EX13 = Yes] Have you changed how frequently you take public transit since the province declared a public health emergency?
|_| Yes – I have stopped taking public transit
|_| Yes – I take public transit less frequently
|_| No
|_| Prefer not to answer
|_| Don't know

For the next two questions, please use the following definitions:

- ***Self-isolation****: no symptoms or positive test, but stayed at home other than essential errands or exercise, including working from home where that was possible*
- ***Quarantine****: did not leave your house or yard due to recent travel, symptoms, positive test, or possible exposure to someone diagnosed with COVID-19*

EX15. To date, have you *self-isolated* during the COVID-19 pandemic?
|_| Yes
|_| No → Skip to EX19
|_| Prefer not to answer → Skip to EX19
|_| Don't know → Skip to EX19

EX16. [IF EX15 = Yes] How long were you in self-isolation?
Number of weeks:_____
|_| Don't know

EX17. [IF EX15 = Yes] How many people (adults and children) living in your home were in self-isolation with you?

Number of people:_____
|_| Don’t know

EX18. [IF EX15 = Yes] Are you still in self-isolation?
|_| Yes
|_| No
|_| Prefer not to answer
|_| Don’t know

EX19. To date, have you or anyone in your household been in *quarantine* during the COVID-19 pandemic?
|_| Yes
|_| No → Skip to EX23
|_| Prefer not to answer → Skip to EX23
|_| Don’t know → Skip to EX23

EX20. [IF EX19 = Yes] If you or anyone in your household is still in quarantine, how long has it been?
Number of days:_____
|_| Members of my household are no longer in quarantine
|_| Don’t know

EX21. [IF EX19 = Yes] If you or anyone in your household has completed quarantine, how long has it been since quarantine was completed?
Number of weeks:_____
|_| Quarantine is ongoing
|_| Don’t know

EX22. [IF EX19 = Yes] Did/Do you have someone to help meet your immediate needs (e.g. food, medicine, etc.)?
|_| Yes
|_| No
|_| Don’t know

EX23. Are you working as a medical professional (physician, nurse, hospital employee, first responder, pharmacist) with exposure to patients?
|_| Yes
|_| No
|_| Prefer not to answer
|_| Don't know

EX24. Are you working as an essential service provider (grocery store attendant, public transit, police, security, etc.) with regular exposure to members of the public?
|_| Yes
|_| No

|_| Prefer not to answer
|_| Don’t know

EX25. Below are a series of statements about COVID-19; please indicate the degree to which you agree or disagree with the statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
COVID-19 poses a major threat to the public	|_|	|_|	|_|	|_|	|_|
I think the situation with COVID-19 is overblown	|_|	|_|	|_|	|_|	|_|
Because of my location, profession, and/or lifestyle, I am personally at a high risk of contracting COVID-19	|_|	|_|	|_|	|_|	|_|
Because of my age and/or pre-existing conditions, I am likely to have serious symptoms if I were to contract COVID-19	|_|	|_|	|_|	|_|	|_|
Because of my age and/or pre-existing conditions, I am likely to need hospitalization if I were to contract COVID-19	|_|	|_|	|_|	|_|	|_|
The seasonal flu is just as dangerous as COVID-19	|_|	|_|	|_|	|_|	|_|
COVID-19 was created in a lab on purpose	|_|	|_|	|_|	|_|	|_|

RISK FACTORS

As COVID-19 virus affects the respiratory system, the next few questions ask about smoking cigarettes, e-cigarettes and cannabis.

RF01. At the present time, do you smoke cigarettes daily, occasionally, or not at all?
|_| Daily (At least one cigarette every day for the past 30 days)
|_| Occasionally (At least one cigarette in the past 30 days, but not every day)
|_| Not at all (You did not smoke at all in the past 30 days) → Skip to RF03

RF02. [IF RF01 = Daily (At least one cigarette every day for the past 30 days) OR Occasionally (At least one cigarette in the past 30 days, but not every day)] Has your smoking changed since March 2020?
|_| No
|_| Yes – smoking more than before
|_| Yes – smoking less than before
|_| Don't know

RF03. Have you ever tried an electronic cigarette, also known as an e-cigarette? ***Vaping products have many names, such as: e-cigarettes, vape pens, vapes, mods, tanks, and e-hookahs. They may also be known by various brand names.***
|_| Yes
|_| No → Skip to RF06
|_| Don't know → Skip to RF06

RF04. [IF RF03 = Yes] In the past 30 days did you use an e-cigarette?
|_| Yes
|_| No
|_| Don't know

RF05. [IF RF03 = Yes] Has your use of e-cigarettes changed since March 2020?
|_| No
|_| Yes – using more than before
|_| Yes – using less than before
|_| Don't know

RF06. Have you used cannabis in the past 12 months?
|_| Yes
|_| No → Skip to RF10
|_| Prefer not to answer → Skip to RF10
|_| Don't know → Skip to RF10

RF07. [IF RF06 = Yes] In the past 12 months, have you used cannabis for any of the following?

|_| Non-medical purposes only
|_| Medical purposes only, either with or without a medical document
|_| Both medical and non-medical purposes
|_| Prefer not to answer
|_| Don’t know

RF08. [IF RF06 = Yes] In the past 12 months, which of the following methods to consume cannabis did you use most often?
|_| Smoked
|_| Vaporized
|_| Consumed in food or drink
|_| Other
|_| Prefer not to answer
|_| Don’t know

RF09. [IF RF06 = Yes] Has your use of cannabis changed since March 2020?
|_| No
|_| Yes – using more often than before
|_| Yes – using less often than before
|_| Don’t know

RF10. On average, over the last year, how often did you drink alcohol?
|_| 6 to 7 times a week
|_| 4 to 5 times a week
|_| 2 to 3 times a week
|_| Once a week
|_| 2 to 3 times a month
|_| About once a month
|_| Less than once a month
|_| Never → Skip to MC01
|_| Don't know → Skip to MC01

RF11. [IF RF10 = ANY OPTION OTHER THAN Never OR Don’t know] Has your alcohol consumption changed since March 2020?
|_| No
|_| Yes – drinking alcohol more often than before
|_| Yes – drinking alcohol less often than before
|_| Don’t know

MEDICAL CONDITIONS

COVID-19 is a new disease and evidence of risk factors continues to evolve. People who have pre-existing medical conditions, or who have compromised immune systems may be at higher risk of serious illness, similar to what is seen with other respiratory illnesses, such as influenza.

MC01. Has a doctor ever told you that you had a cancer or a malignancy of any kind?
|_| Yes, select all that apply
|_| No → Skip to MC05
|_| Don't know → Skip to MC05

MC02. [IF MC01 = Yes]

|_| Breast	**[IF SELECTED] Are you currently undergoing treatment for breast cancer?** |_| Yes |_| No |_| Don't know
|_| Colon	**[IF SELECTED] Are you currently undergoing treatment for colon cancer?** |_| Yes |_| No |_| Don't know
|_| Leukemia	**[IF SELECTED] Are you currently undergoing treatment for leukemia?** |_| Yes |_| No |_| Don't know
|_| Lung and bronchus	**[IF SELECTED] Are you currently undergoing treatment for lung and bronchus cancer?** |_| Yes |_| No |_| Don't know
|_| Lymphoma (Hodgkin Lymphoma)	**[IF SELECTED] Are you currently undergoing treatment for lymphoma (Hodgkin lymphoma) cancer?** |_| Yes |_| No |_| Don't know
|_| Lymphoma (non-Hodgkin Lymphoma)	**[IF SELECTED] Are you currently undergoing treatment for lymphoma (Non-Hodgkin lymphoma) cancer?**

	|_| Yes |_| No |_| Don't know
|_| Pancreatic	**[IF SELECTED] Are you currently undergoing treatment for pancreatic cancer?** |_| Yes |_| No |_| Don't know
|_| Prostate	**[IF SELECTED] Are you currently undergoing treatment for prostate cancer?** |_| Yes |_| No |_| Don't know
|_| Rectum	**[IF SELECTED] Are you currently undergoing treatment for rectal cancer?** |_| Yes |_| No |_| Don't know
|_| Skin (Melanoma)	**[IF SELECTED] Are you currently undergoing treatment for skin (melanoma) cancer?** |_| Yes |_| No |_| Don't know
|_| Skin (Non-Melanoma)	**[IF SELECTED] Are you currently undergoing treatment for skin (non-melanoma) cancer?** |_| Yes |_| No |_| Don't know
|_| Thyroid	**[IF SELECTED] Are you currently undergoing treatment for thyroid cancer?** |_| Yes |_| No |_| Don't know
|_| Uterus	**[IF SELECTED] Are you currently undergoing treatment for uterine cancer?** |_| Yes |_| No |_| Don't know

MC03. Have you been diagnosed with any other type of cancer or malignancy?
|_| Yes – please specify:_____
|_| No → Skip to MC05
|_| Don't know → Skip to MC05

MC04. [IF MC03 = Yes] Are you currently undergoing treatment for the other cancer or malignancy specified?
|_| Yes
|_| No
|_| Don't know

MC05. Has a doctor ever told you that you had any of the following conditions?

Condition	Diagnosed	Are you currently being treated?
Diabetes	|_| Yes |_| No → Skip to Heart and circulatory conditions |_| Don't know → Skip to Heart and circulatory conditions **If yes, which type of diabetes was it?**	
	|_| Type 1 diabetes	**[IF SELECTED] Are you currently being treated for Type 1 diabetes?** |_| Yes |_| No |_| Don't know
	|_| Type 2 diabetes	**[IF SELECTED] Are you currently being treated for Type 2 diabetes?** |_| Yes |_| No |_| Don't know
	|_| Gestational diabetes only	**[IF SELECTED] Are you currently being treated for gestational diabetes?** |_| Yes |_| No |_| Don't know
Heart and circulatory conditions	|_| Yes, select all that apply |_| No → Skip to Respiratory system conditions	

Condition	Diagnosed	Are you currently being treated?
	|_| Don't know → Skip to Respiratory system conditions	
	|_| High blood pressure (hypertension, not including during pregnancy)	**[IF SELECTED] Are you currently being treated for high blood pressure (hypertension, not including during pregnancy)?** |_| Yes |_| No |_| Don't know
	|_| Heart attack (myocardial infarction)	**[IF SELECTED] Are you currently being treated for a heart attack (myocardial infarction)?** |_| Yes |_| No |_| Don't know
	|_| Heart failure	**[IF SELECTED] Are you currently being treated for heart failure?** |_| Yes |_| No |_| Don't know
	|_| Atherosclerosis / Coronary heart disease (including angioplasty or stents)	**[IF SELECTED] Are you currently being treated for atherosclerosis / coronary heart disease (including angioplasty or stents)?** |_| Yes |_| No |_| Don't know
	|_| Atrial fibrillation	**[IF SELECTED] Are you currently being treated for atrial fibrillation?** |_| Yes |_| No |_| Don't know
	|_| Angina	**[IF SELECTED] Are you currently being treated for angina?** |_| Yes

Condition	Diagnosed	Are you currently being treated?
		|_| No |_| Don't know
	|_| Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)	**[IF SELECTED] Are you currently being treated for valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)?** |_| Yes |_| No |_| Don't know
Respiratory system conditions	|_| Yes, select all that apply |_| No → Skip to Gastrointestinal conditions |_| Don't know → Skip to Gastrointestinal conditions	
	|_| Asthma	**[IF SELECTED] Are you currently being treated for asthma?** |_| Yes |_| No |_| Don't know
	|_| Chronic obstructive pulmonary disease (COPD)	**[IF SELECTED] Are you currently being treated for chronic obstructive pulmonary disease (COPD)?** |_| Yes |_| No |_| Don't know
	|_| Interstitial lung disease (lung tissue scarring resulting from other health conditions or exposures)	**[IF SELECTED] Are you currently being treated for interstitial lung disease?** |_| Yes |_| No |_| Don't know
	|_| Chronic bronchitis	**[IF SELECTED] Are you currently being treated for chronic bronchitis?** |_| Yes |_| No |_| Don't know

Condition	Diagnosed	Are you currently being treated?
	|_| Cystic fibrosis	**[IF SELECTED] Are you currently being treated for cystic fibrosis?** |_| Yes |_| No |_| Don't know
	|_| Emphysema	**[IF SELECTED] Are you currently being treated for emphysema?** |_| Yes |_| No |_| Don't know
	|_| Sleep apnea	**[IF SELECTED] Are you currently being treated for sleep apnea?** |_| Yes |_| No |_| Don't know
Gastrointestinal conditions	|_| Yes, select all that apply |_| No → Skip to Liver or pancreas conditions |_| Don't know → Skip to Liver or pancreas conditions	
	|_| Crohn's disease	**[IF SELECTED] Are you currently being treated for Crohn's disease?** |_| Yes |_| No |_| Don't know
	|_| Ulcerative colitis	**[IF SELECTED] Are you currently being treated for ulcerative colitis?** |_| Yes |_| No |_| Don't know
	|_| Irritable bowel syndrome	**[IF SELECTED] Are you currently being treated for irritable bowel syndrome?** |_| Yes |_| No |_| Don't know

Condition	Diagnosed	Are you currently being treated?
	|_| Celiac disease	**[IF SELECTED] Are you currently being treated for celiac disease?** |_| Yes |_| No |_| Don't know
Liver or pancreas conditions	|_|Yes, select all that apply |_|No → Skip to Renal disease / kidney failure conditions |_|Don't know → Skip to Renal disease / kidney failure conditions	
	|_| Liver cirrhosis	**[IF SELECTED] Are you currently being treated for liver cirrhosis?** |_| Yes |_| No |_| Don't know
	|_| Chronic hepatitis	**[IF SELECTED] Are you currently being treated for chronic hepatitis?** |_| Yes |_| No |_| Don't know
	|_| Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)	**[IF SELECTED] Are you currently being treated for fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)?** |_| Yes |_| No |_| Don't know
Renal disease / kidney failure conditions	|_| Yes, select all that apply |_| No → Skip to Mental health conditions |_| Don't know → Skip to Mental health conditions	
	|_| Acute renal failure	**[IF SELECTED] Are you currently being treated for acute renal failure?**

Condition	Diagnosed	Are you currently being treated?
		|_| Yes |_| No |_| Don't know
	|_| Chronic renal failure	**[IF SELECTED] Are you currently being treated for chronic renal failure?** |_| Yes |_| No |_| Don't know
Mental health conditions	|_| Yes, select all that apply |_| No → Skip to neurological conditions |_| Don't know → Skip to neurological conditions	
	|_| Major depression	**[IF SELECTED] Are you currently being treated for major depression?** |_| Yes |_| No |_| Don't know
	|_| Minor depression	**[IF SELECTED] Are you currently being treated for minor depression?** |_| Yes |_| No |_| Don't know
	|_| Bipolar disorder	**[IF SELECTED] Are you currently being treated for bipolar disorder?** |_| Yes |_| No |_| Don't know
	|_| Post-traumatic stress disorder	**[IF SELECTED] Are you currently being treated for post-traumatic stress disorder?** |_| Yes |_| No |_| Don't know
	|_| Schizophrenia or Schizoaffective disorder	**[IF SELECTED] Are you currently being treated for schizophrenia or schizoaffective disorder?**

Condition	Diagnosed	Are you currently being treated?
		|_| Yes |_| No |_| Don't know
	|_| Obsessive compulsive disorder	**[IF SELECTED] Are you currently being treated for obsessive compulsive disorder?** |_| Yes |_| No |_| Don't know
	|_| Anxiety disorder	**[IF SELECTED] Are you currently being treated for anxiety disorder?** |_| Yes |_| No |_| Don't know
	|_| Eating disorder	**[IF SELECTED] Are you currently being treated for an eating disorder?** |_| Yes |_| No |_| Don't know
	|_| Addiction disorder (e.g. alcohol, drug or gambling dependence)	**[IF SELECTED] Are you currently being treated for an addiction disorder (e.g. alcohol, drug or gambling dependence)?** |_| Yes |_| No |_| Don't know
Neurological conditions	|_| Yes, select all that apply |_| No → Skip to Bone and joint conditions |_|Don't know → Skip to Bone and joint conditions	
	|_|Thrombotic stroke	**[IF SELECTED] Are you currently being treated for thrombotic stroke?** |_| Yes |_| No |_| Don't know

Condition	Diagnosed	Are you currently being treated?
	|_| Hemorrhagic stroke	**[IF SELECTED] Are you currently being treated for hemorrhagic stroke?** |_| Yes |_| No |_| Don't know
	|_| Multiple sclerosis	**[IF SELECTED] Are you currently being treated for multiple sclerosis?** |_| Yes |_| No |_| Don't know
Bone and joint conditions	|_| Yes, select all that apply |_| No → Skip to Skin conditions |_| Don't know → Skip to Skin conditions	
	|_| Arthritis **[IF SELECTED] Which type(s) of arthritis was it? *Select all that apply*:** |_| Rheumatoid arthritis |_| Osteoarthritis |_| Other - please specify: _____ |_| Don't know	**[IF SELECTED] Are you currently being treated for arthritis?** |_| Yes |_| No |_| Don't know
	|_| Lupus	**[IF SELECTED] Are you currently being treated for lupus?** |_| Yes |_| No |_| Don't know
	|_| Fibromyalgia	**[IF SELECTED] Are you currently being treated for fibromyalgia?** |_| Yes |_| No |_| Don't know

Condition	Diagnosed	Are you currently being treated?
Skin conditions	|_| Yes, select all that apply |_| No → Skip to Immune system conditions |_| Don't know → Skip to Immune system conditions	
	|_| Eczema	**[IF SELECTED] Are you currently being treated for eczema?** |_| Yes |_| No |_| Don't know
	|_| Psoriasis	**[IF SELECTED] Are you currently being treated for psoriasis?** |_| Yes |_| No |_| Don't know
	|_| Scleroderma	**[IF SELECTED] Are you currently being treated for scleroderma?** |_| Yes |_| No |_| Don't know
Immune system conditions	|_| Yes, select all that apply |_| No → Skip to MC06 |_| Don't know → Skip to MC06	
	|_| HIV	**[IF SELECTED] Are you currently being treated for HIV?** |_| Yes |_| No |_| Don't know
	|_| A weakened or compromised immune system such as Severe Combined Immunodeficiency)	**[IF SELECTED] Are you currently being treated for a weakened or compromised immune system (such as severe combined immunodeficiency)?** |_| Yes

Condition	Diagnosed	Are you currently being treated?
		|_| No |_| Don't know
	|_| Hashimoto's thyroiditis, Sjögren's syndrome, or Ankylosing spondylitis	**[IF SELECTED] Are you currently being treated for Hashimoto's thyroiditis, Sjögren's syndrome, or ankylosing spondylitis?** |_| Yes |_| No |_| Don't know

MC06. Do you have or have you had any other medical conditions?
|_| Yes
|_| No → Skip to MC17
|_| Don't know → Skip to MC17

[IF MC06 = Yes] Please list these medical conditions:

MC07. 1: _____

MC08. Are you currently being treated for the other medical condition specified above?
|_| Yes
|_| No
|_| Don't know

MC09. 2: _____

MC10. Are you currently being treated for the other medical condition specified above?
|_| Yes
|_| No
|_| Don't know

MC11. 3: _____

MC12. Are you currently being treated for the other medical condition specified above?
|_| Yes
|_| No
|_| Don't know

MC13. 4: _____

MC14. Are you currently being treated for the other medical condition specified above?
|_| Yes
|_| No
|_| Don't know

MC15. 5: _____

MC16. Are you currently being treated for the other medical condition specified above?
|_| Yes
|_| No
|_| Don't know

MC17. Have you ever received an organ, bone marrow, or stem cell transplant?
|_| Yes
|_| No → Skip to MC19
|_| Don't know → Skip to MC19

MC18. [IF MC17 = Yes] Are you currently taking immunosuppressive medication?
|_| Currently taking each day
|_| Taken within the last few months (during the COVID-19 pandemic) but not every day
|_| Taken before Jan 2020 but not currently
|_| No
|_| Don't know

MC19. What is your blood type?
|_| A
|_| B
|_| AB
|_| O
|_| Prefer not to answer
|_| Don't Know

MC20. Since March 2020, access to health services may have changed. Have you experienced any of the following changes related to your healthcare?
Select all that apply:
|_| Surgery cancelled or deferred
|_| Medical procedure cancelled or deferred
|_| Treatment cancelled or deferred
|_| Other health-related appointment cancelled or deferred (e.g. dental, vision, etc.)
|_| Use of virtual appointments with health care provider
|_| Delayed seeing a healthcare professional about an existing problem or concern

|_| Delayed seeing a healthcare professional about a new problem or concern
|_| Regular lab tests cancelled or deferred
|_| Medication shortage
|_| Other – please specify:_____
|_| None or not applicable

MEDICATION

ME01. Are you currently taking or have you taken in the past 12 months any of the medications listed below?
|_| Yes, select all that apply
|_| No → Skip to PI01
|_| Don't know → Skip to PI01

Medication Type	How often?
|_| ACE-inhibitors to lower blood pressure (e.g. benazepril, captopril, enalapril, lisinopril, ramipril)	**[IF SELECTED] How often do or did you take ACE-inhibitors to lower blood pressure (e.g. benazepril, captopril, enalapril, lisinopril, ramipril)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Angiotension II Receptor Blockers to lower blood pressure (e.g. candesartan, losartan, telmisartan, valsartan)	**[IF SELECTED] How often do or did you take angiotensin II receptor blockers to lower blood pressure (e.g. candesartan, losartan, telmisartan, valsartan)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Antibiotics	**[IF SELECTED] How often do or did you take antibiotics?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Antivirals (e.g. lopinavir-ritonavir, remdesivir)	**[IF SELECTED] How often do or did you take antivirals (e.g. lopinavir-ritonavir, remdesivir)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know

Medication Type	How often?
|_| Allergy medications	**[IF SELECTED] How often do or did you take allergy medications?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Androgen deprivation therapy	**[IF SELECTED] How often do or did you take androgen deprivation therapy?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Asthma medications	**[IF SELECTED] How often do or did you take asthma medication?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Immunosuppressive or immunomodulatory medication (e.g. corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)	**[IF SELECTED] How often do or did you take immunosuppressive or immunomodulatory medication (e.g. corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Blood thinners (e.g. apixaban, rivaroxaban, dabigatran)	**[IF SELECTED] How often do or did you take blood thinners (e.g. apixaban, rivaroxaban, dabigatran)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day

Medication Type	How often?
	|_| Taken before Jan 2020 but not currently |_| Don't know
|_| Non-steroidal anti-inflammatory drugs (e.g. ibuprofen such as Advil or Motrin; naproxen such as Aleve)	**[IF SELECTED] How often do or did you take non-steroidal anti-inflammatory drugs (e.g. ibuprofen such as Advil or Motrin; naproxen such as Aleve)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know
|_| Other pain/fever relievers (e.g. aspirin, paracetamol or acetaminophen)	**[IF SELECTED] How often do or did you take other pain/fever relievers (e.g. aspirin, paracetamol or acetaminophen)?** |_| Currently taking each day |_| Taken within the last few months (during the COVID-19 pandemic) but not every day |_| Taken before Jan 2020 but not currently |_| Don't know

MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since March 2020 when COVID-19 was declared a pandemic. ***Please note that a mental health professional will not follow-up with you if your responses to these questions suggest you are in distress.*** *If you are experiencing stress or anxiety and would like to access support, please reach out to mental health services available in your area.*

PI01. Since March 2020, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half of the days	Nearly every day
Feeling nervous, anxious, or on edge	|_| → Skip to PI03	|_|	|_|	|_|
Not being able to stop or control worrying	|_| → Skip to PI03	|_|	|_|	|_|
Worrying too much about different things	|_| → Skip to PI03	|_|	|_|	|_|
Trouble relaxing	|_| → Skip to PI03	|_|	|_|	|_|
Being so restless that it's hard to sit still	|_| → Skip to PI03	|_|	|_|	|_|
Becoming easily annoyed or irritable	|_| → Skip to PI03	|_|	|_|	|_|
Feeling afraid as if something awful might happen	|_| → Skip to PI03	|_|	|_|	|_|

PI02. [IF PI01 = ANY OPTION OTHER THAN Not at all] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

|_| Not difficult at all
|_| Somewhat difficult
|_| Very difficult
|_| Extremely difficult

PI03. Since March 2020, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half of the days	Nearly every day
Little interest or pleasure in doing things	|_| → Skip to PI05	|_|	|_|	|_|
Feeling down, depressed or hopeless	|_| → Skip to PI05	|_|	|_|	|_|
Trouble falling or staying asleep, or sleeping too much	|_| → Skip to PI05	|_|	|_|	|_|
Feeling tired or having little energy	|_| → Skip to PI05	|_|	|_|	|_|
Poor appetite or overeating	|_| → Skip to PI05	|_|	|_|	|_|
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	|_| → Skip to PI05	|_|	|_|	|_|
Trouble concentrating on things, such as reading the newspaper or watching television	|_| → Skip to PI05	|_|	|_|	|_|
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	|_| → Skip to PI05	|_|	|_|	|_|

PI04. [IF PI03 = ANY OPTION OTHER THAN Not at all] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

|_| Not difficult at all
|_| Somewhat difficult
|_| Very difficult
|_| Extremely difficult

PI05. We would like you to compare your mental and emotional health before March 2020 to now.

	Excellent	Very Good	Good	Fair	Poor

In general, would you say your current mental/emotional health is:	|_|	|_|	|_|	|_|	|_|
		Better	**About the Same**		**Worse**
Your current mental/emotional health now compared to before March 2020:		|_|	|_|		|_|

PI06. Stressful situations have the potential to affect the relationships around you. We understand that many things may have changed in your life due to the impact of COVID-19. In the next set of questions, we are interested in how your relationships have changed since March 2020.

My relationship with:	N/A	Has become closer than before the pandemic	Is about the same as before the pandemic	Is more distant or strained than before the pandemic
Intimate partner	|_|	|_|	|_|	|_|
Other family members (excluding intimate partner)	|_|	|_|	|_|	|_|
Friends	|_|	|_|	|_|	|_|
Neighbours	|_|	|_|	|_|	|_|
People you don't know but are in your community	|_|	|_|	|_|	|_|
Work colleagues	|_|	|_|	|_|	|_|

PI07. Since March 2020, have you accessed mental health services?
Select all that apply:

|_| No → Skip to PI09
|_| Yes – using resources that I already had in place
|_| Yes – I have initiated new use of services
|_| Prefer not to answer → Skip to PI09
|_| Don't know → Skip to PI09

PI08. [IF PI07 = Yes – using resources that I already had in place OR Yes – I have initiated new use of services] Did you access mental health services for any of the following conditions?
Select all that apply:
|_| Anxiety
|_| Depression
|_| Stress
|_| Other – please specify:_____
|_| Prefer not to answer
|_| Don't know

PI09. Since March 2020, has anyone in your household accessed mental health services?
Select all that apply:
|_| No
|_| Yes – using resources that they already had in place
|_| Yes – they have initiated new use of services
|_| Not applicable – I live alone
|_| Prefer not to say
|_| Don’t know

SOCIAL & ECONOMIC IMPACT

The March, 2020 declaration of a global pandemic has devastated local communities and economies and many people have had their livelihoods affected. With this next set of questions, we want to understand how your family's ability to meet its essential needs and financial obligations have been impacted, and ask whether your family has given or received support in your community.

SI01. Prior to March 2020, what was your employment status?
Full time means 30 hours or more per week. Part time means less than 30 hours per week.
|_| Full-time employed / self-employed
|_| Part-time employed / self-employed
|_| Retired
|_| Looking after home and/or family
|_| Unable to work because of sickness or disability
|_| Unemployed
|_| Doing unpaid or voluntary work
|_| Student
|_| Prefer not to answer → Skip to SI04

SI02. [IF SI01 = ANY OPTION OTHER THAN Prefer not to answer] Has anything about your employment changed because of the pandemic (e.g. working from home)?
|_| No → Skip to SI04
|_| Yes

SI03. [IF SI02 = Yes] What has changed about your employment?
Select all that apply.
|_| Nature of work has changed
|_| External workplace has changed
|_| Work from home
|_| Reduced wages/ hours
|_| Loss of employment
|_| Redeployed into healthcare for pandemic response
|_| Redeployed into other essential services for pandemic response
|_| Other – please specify:_____
|_| Prefer not to answer

SI04. Prior to the pandemic, what was your approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.
|_| Less than $10,000
|_| $10,000 - $24,999
|_| $25,000 - $49,999
|_| $50,000 - $74,999

|_| $75,000 - $99,999
|_| $100,000 - $149,999
|_| $150,000 - $199,999
|_| $200,000 or more
|_| Prefer not to answer
|_| Don’t know

SI05. Has your monthly household income been changed because of the COVID-19 pandemic?
|_| Substantially decreased
|_| Somewhat decreased
|_| No change
|_| Somewhat increased
|_| Substantially increased

SI06. Have your household savings been changed because of the COVID-19 pandemic?
|_| Substantially decreased
|_| Somewhat decreased
|_| No change
|_| Somewhat increased
|_| Substantially increased

SI07. Which of the following best describes the impact of COVID-19 on your ability to meet financial obligations or essential needs, such as rent or mortgage payments, utilities and groceries?
|_| Major impact
|_| Moderate impact
|_| Minor impact
|_| No impact
|_| Too soon to tell

SI08. Since March 2020, has anyone in your household ever received food from a food bank, soup kitchen or other charitable agency?
|_| Yes
|_| No → Skip to SI10
|_| Prefer not to answer → Skip to SI10
|_| Don’t know → Skip to SI10

SI09. [IF SI08 = Yes] How many times? _____

SI10. On a scale of 1 to 7, please indicate how much you worry about having enough money to do what is important for you/your family:

1(Rarely/never)	2	3	4	5	6	7(Always)
|_|	|_|	|_|	|_|	|_|	|_|	|_|

SI11. On a scale of 1 to 7, please indicate if you have the financial resources you need to meet you/your family's needs:

1(Rarely/never)	2	3	4	5	6	7(Always)
|_|	|_|	|_|	|_|	|_|	|_|	|_|

SI12. We'd like to ask you about giving and receiving support during the pandemic. Since March 2020, have you *provided* help, aid or support to others (friends, family, neighbours, community/volunteer organization, colleagues) because of the pandemic?

|_| Yes
|_| No → Skip to SI14
|_| Don't know → Skip to SI14

SI13. [IF SI12 = Yes] What kind of help, aid or support did you provide and for whom? (Check all that apply)

	Emotional/ psychological	Financial	Medical	Information	Practical support (e.g. housing, childcare, clean-up, food delivery)	Material goods/donations (e.g. furniture, clothing)
Family (spouse, parent, other relatives)	|_|	|_|	|_|	|_|	|_|	|_|
Friend(s)/ Neighbour(s)	|_|	|_|	|_|	|_|	|_|	|_|
Community /volunteer organization	|_|	|_|	|_|	|_|	|_|	|_|
Colleagues	|_|	|_|	|_|	|_|	|_|	|_|

SI14. Since March 2020, have you *looked* for help, aid or support (including from friends, family, community or government) because of the pandemic?

|_| Yes
|_| No
|_| Don't know

SI15. Since March 2020, have you *received* help, aid, information or support (including from friends, family, community or government) because of the pandemic?

|_| Yes
|_| No → Skip to AM01
|_| Don't know → Skip to AM01

SI16. [IF SI15 = Yes] what kind of help, aid or support did you receive and from whom? (Check all that apply)

	Emotional/ psychological	**Financial**	**Medical**	**Information**	**Practical support (e.g. housing, childcare, clean-up, food delivery)**	**Material goods/donations (e.g. furniture, clothing)**
Family (spouse, parent, other relatives)	|_|	|_|	|_|	|_|	|_|	|_|
Friend(s)/ Neighbour(s)	|_|	|_|	|_|	|_|	|_|	|_|
Community/ volunteer organization	|_|	|_|	|_|	|_|	|_|	|_|
Colleagues	|_|	|_|	|_|	|_|	|_|	|_|
Professional (doctor, lawyer, teacher, counsellor, spiritual leader, financial advisor)	|_|	|_|	|_|	|_|	|_|	|_|
General media (TV, internet, social media)	|_|	|_|	|_|	|_|	|_|	|_|
Provincial or Federal Health authorities (e.g. help/information phone lines, websites, social media)	|_|	|_|	|_|	|_|	|_|	|_|
Government (financial support, financial relief, resources)	|_|	|_|	|_|	|_|	|_|	|_|

ANTHROPOMETRICS

Not only does our height and weight change as we age, the COVID-19 pandemic may have caused changes in your eating and activity habits. Please tell us your current height and weight, following the measurement instructions provided.

AM01. How tall are you?
Please answer the question using feet and inches or centimeters. If entering your height in feet and inches, please include a number for BOTH feet and inches.
Feet_____ & Inches _____
Centimetres_____
|_| Prefer not to answer
|_| Don't know

AM02. How much do you weigh?

- ***Adjust your scale to zero;***
- ***Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.***
- ***Step on the scale. Make sure both feet are fully on the scale.***
- ***Record your weight in pounds or kilograms.***

Pounds_____
Kilograms_____
|_| Prefer not to answer
|_| Don't know

EXIT SURVEY

[All questions non-mandatory]

This section is optional. If you do not want to answer these questions, please scroll down and click “Finish” to submit your questionnaire.

1. **Please indicate below if you agree with the following statement: I found the questionnaire easy to use.**
   |_| Strongly agree → Skip to 2
   |_| Agree → Skip to 2
   |_| Neutral → Skip to 2
   |_| Disagree
   |_| Strongly disagree

   [IF 1 = Disagree OR Strongly disagree] Please select the reason(s) you did not find the questionnaire easy to use
   Select all that apply:
   |_| The questions were too personal
   |_| The questions were upsetting
   |_| I did not understand the questions
   |_| The questionnaire took too long to complete
   |_| Other (please specify):_____

2. **Did you have help completing this questionnaire?**
   Select all that apply:
   |_| No
   |_| I needed help translating some of the questions
   |_| I needed computer help to use the online questionnaire
   |_| Someone else entered the responses because I have limited mobility
   |_| I asked my spouse or contacted family members for responses to some of the questions
   |_| Other (please specify):
   _____

3. **Were there questions you found unclear or hard to understand? If yes, what were those questions about?**
   _____

4. **What else could we do to keep you as an active participant in the Study?**
   _____

5. **Is there anything else you would like to tell us about your experience completing this questionnaire?**

_____
_____

6. **What was your most trusted source of COVID-19 related information during the pandemic?**
   |_| Federal announcements by public health and political leaders
   |_| Provincial announcements by public health and political leaders
   |_| Municipal announcements by public health and political leaders
   |_| Data posted by academic institutions
   |_| Local and national news outlets
   |_| A non-Canadian news source
   |_| Social media
   |_| Family, friends or colleagues
   |_| Other (please specify):_____