

# CanPath COVID-19 Antibody Study Questionnaire



Funding provided from the COVID-19 Immunity Task Force and the Canadian Institutes of Health Research.

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## **DIRECTIONS FOR COMPLETING THIS QUESTIONNAIRE**

Thank you for completing the 2020 CanPath COVID-19 questionnaire and agreeing to submit a blood spot sample to be tested for COVID-19 antibodies.

This COVID-19 Antibody Study questionnaire is designed to learn about changes to your health, both physical and mental, from the impact of COVID-19 since the start of the pandemic.

This questionnaire must be completed within **1 WEEK** of receiving it. 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.

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.

Once you click "Finish" to complete this questionnaire, a blood spot sample kit will be mailed to you.

## COVID-19 DIAGNOSES

**DG01. Do you think you currently have, or have had, COVID-19?**

- Yes
- No → Skip to DG05
- Don't know → Skip to DG05

**DG02. [If DG01 = Yes] Why do you think you have, or have had, COVID-19?**

**Select all that apply:**

- Took a self-assessment online → Skip to DG05
- Had symptoms that could be COVID-related (e.g., fever, sore throat, runny nose, difficulty breathing, etc.) that cannot be attributed to a previously existing condition → Skip to DG05
- Nasal/throat test result → Skip to DG05
- Told by a health care provider → Skip to DG05
- Had contact with someone who tested positive for COVID-19
- Other – please specify: \_\_\_\_\_ → Skip to DG05

**DG03. [If DG02 = Had contact with someone who tested positive for COVID-19] On which date did you have first contact with this person after they were diagnosed with COVID-19?**

***If you don't remember exactly when, please choose an approximate date.***

\_\_\_\_\_ (DD-MM-YYYY)

- Don't know

**DG04. [If DG02 = Had contact with someone who tested positive for COVID-19] 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: \_\_\_\_\_

**DG05. As of today, have you been tested for COVID-19 (including a nasal swab and/or blood testing)?**

- Yes
- No → Skip to SY01

**DG06. [If DG05 = Yes] How many times have you been tested? For serology/antibody testing please do not include the test you will be doing as part of this study.**

***A maximum of 8 tests can be reported. Please report all positive tests. If you have had more than 8 tests, report all positive tests first, followed by other test results, to a maximum of 8.***

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

**DG07. [If DG06 = 1] For your first test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG08. [If DG06 = 1] What was the date of your first test?**

***If you don't remember exactly when, please choose an approximate date.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG09. [If DG06 = 1] What was the result of your first test?**

- Negative
- Positive
- Don't know

**DG10. [If DG06 = 2] For your second test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG11. [If DG06 = 2] What was the date of your second test?**

***Note: The date entered must be later than, or the same as, the date of your first test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG12. [If DG06 = 2] What was the result of your second test?**

- Negative
- Positive
- Don't know

**DG13. [If DG06 = 3] For your third test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG14. [If DG06 = 3] What was the date of your third test?**

***Note: The date entered must be later than, or the same as, the date of your second test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG15. [If DG06 = 3] What was the result of your third test?**

- Negative
- Positive
- Don't know

**DG16. [If DG06 = 4] For your fourth test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG17. [If DG06 = 4] What was the date of your fourth test?**

***Note: The date entered must be later than, or the same as, the date of your third test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG18. [If DG06 = 4] What was the result of your fourth test?**

- Negative
- Positive
- Don't know

**DG19. [If DG06 = 5] For your fifth test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG20. [If DG06 = 5] What was the date of your fifth test?**

***Note: The date entered must be later than, or the same as, the date of your fourth test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG21. [If DG06 = 5] What was the result of your fifth test?**

- Negative
- Positive
- Don't know

**DG22. [If DG06 = 6] For your sixth test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG23. [If DG06 = 6] What was the date of your sixth test?**

***Note: The date entered must be later than, or the same as, the date of your fifth test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG24. [If DG06 = 6] What was the result of your sixth test?**

- Negative
- Positive
- Don't know

**DG25. [If DG06 = 7] For your seventh test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG26. [If DG06 = 7] What was the date of your seventh test?**

***Note: The date entered must be later than, or the same as, the date of your sixth test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG27. [If DG06 = 7] What was the result of your seventh test?**

- Negative
- Positive
- Don't know

**DG28. [If DG06 = 8] For your eighth test, what was the type of test?**

- Viral test (a nasal or throat swab for current infection)
- Antibody/serology test (blood test for past infection)

**DG29. [If DG06 = 8] What was the date of your eighth test?**

***Note: The date entered must be later than, or the same as, the date of your seventh test. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

**DG30. [If DG06 = 8] What was the result of your eighth test?**

- Negative
- Positive
- Don't know



## **COVID-19 CARE/HOSPITAL RELATED INFORMATION**

The following questions are presented to participants with a positive test result for COVID-19.

**CH01. Were you hospitalized because of COVID-19?**

Yes

No → Skip to SY01

**CH02. [If CH01 = Yes] What date did you get admitted to the hospital?  
If you don't remember exactly when, please choose an approximate date.**

\_\_\_\_\_ (DD-MM-YYYY)

Don't know

**CH03. [If CH01 = Yes] How many days were you in the hospital?**

**Note: to register your answers after you've typed them, simply click somewhere else on the page.**

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: If you don't remember the exact duration, please provide the best estimate that you can. This response must be less than or equal to the number of days spent in the hospital. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.**

Number of days: \_\_\_\_\_

Don't know

**CH06. [If CH01 = Yes] Did you continue to experience COVID-19 symptoms or complications related to hospitalization after you were discharged?**

Yes

No

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. 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.**

- Fever  $\geq 38^{\circ}\text{C}$
- Dry Cough
- Wet cough (a cough that produces mucus)
- Runny nose
- Sinus pain
- Ear pain
- Sore throat
- Hoarseness
- Shortness of breath or difficulty breathing
- Headache
- 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
- Wheezing
- Chest pain
- Confusion
- Dizziness
- Abdominal pain
- Other respiratory symptoms

Yes

No → Skip to EX01

**SY02. [If SY01 = Yes] Please indicate which symptoms you've experienced and the severity. Please be sure to respond to all symptoms.**

	No	Mild	Severe
Fever $\geq 38^{\circ}\text{C}$	_	_	_
Dry Cough	_	_	_
Wet cough (Cough that produces mucus)	_	_	_
Runny nose	_	_	_
Sinus pain	_	_	_
Ear pain	_	_	_
Sore throat	_	_	_
Hoarseness	_	_	_
Shortness of breath or difficulty breathing	_	_	_
Headache	_	_	_
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	_	_	_
Wheezing	_	_	_
Chest pain	_	_	_
Confusion	_	_	_
Dizziness	_	_	_
Abdominal pain	_	_	_
Other respiratory symptoms	_	_	_

**SY03. [If SY01 = Yes] Did you experience any other symptoms not listed above?**

- Yes – please specify: \_\_\_\_\_
- No other symptoms

**SY04. [If SY03 = Yes] How severe were these other symptoms?**

- Mild
- Severe
- Don't know

**SY05. [If SY02 = Mild OR Severe FOR ANY SYMPTOM; If SY03 = 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

**SY06. [If SY02 = Mild OR Severe FOR ANY SYMPTOM; If SY03 = Yes] When did you experience the most *recent* symptoms?**

***Note: The date entered must be later than, or the same as, the date you first experienced symptoms. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.***

\_\_\_\_\_ (DD-MM-YYYY)

- Don't know

**SY07. [If SY02 = Mild OR Severe FOR ANY SYMPTOM; If SY03 = Yes] While you were experiencing COVID-19 related symptoms, did you have close contact with any of the following people? 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family members living in the same place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family members living in another place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housemates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SY08. [If SY07 = Yes] Has any of those person(s) developed COVID-related symptoms?**

- Yes
- No
- Don't know

**SY09. [If SY08 = 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. Note: Values between 1-30 accepted. Please use numbers only. Avoid special characters such as “/”.**

- 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: \_\_\_\_\_

**SY10. [If SY02 = Mild OR Severe FOR ANY SYMPTOM; If SY03 = Yes] Do you continue to experience COVID-19 symptoms or complications?**

- Yes
- No
- Don't know

## COVID-19 EXPOSURE

**EX01. Did you travel outside your home province since January 1, 2020?**

- Yes  
 No → Skip to EX04

**EX02. [if EX01 = Yes] What province or country did you travel to?**

**Select all that apply:**

- Alberta
- British Columbia
- Manitoba
- New Brunswick
- Newfoundland & Labrador
- Northwest Territories
- Nova Scotia
- Nunavut
- Ontario
- Prince Edward Island
- Quebec
- Saskatchewan
- Yukon
- Australia
- Caribbean countries
- China
- France
- Germany
- India
- Iran
- Italy
- Mexico
- New Zealand
- Thailand
- United Kingdom
- United States of America
- Other(s) – please specify (please separate by commas – e.g., Brazil, Malaysia, etc.): \_\_\_\_\_

**EX03.**

<p><b>[If EX02 = Alberta]</b>  <b>How many times did you travel to Alberta since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = Alberta]</b>  <b>When did you travel to Alberta?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 30%; text-align: center;">Return Date</td> </tr> <tr> <td>First trip:</td> <td style="text-align: center;">_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td style="text-align: center;">_____ (DD-MM-YYYY)</td> </tr> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)
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	Third trip (if applicable): _____ (DD-MM-YYYY) Fourth trip (if applicable): _____ (DD-MM-YYYY) Fifth trip (if applicable): _____ (DD-MM-YYYY)												
<b>[If EX02 = British Columbia]</b> <b>How many times did you travel to British Columbia since January 1, 2020?</b> _____	<b>[If EX02 = British Columbia]</b> <b>When did you travel to British Columbia?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<b>[If EX02 = Manitoba]</b> <b>How many times did you travel to Manitoba since January 1, 2020?</b> _____	<b>[If EX02 = Manitoba]</b> <b>When did you travel to Manitoba?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<b>[If EX02 = New Brunswick]</b> <b>How many times did you travel to New Brunswick since January 1, 2020?</b> _____	<b>[If EX02 = New Brunswick]</b> <b>When did you travel to New Brunswick?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<b>[If EX02 = Newfoundland &amp; Labrador]</b> <b>How many times did you travel to Newfoundland &amp; Labrador since January 1, 2020?</b> _____	<b>[If EX02 = Newfoundland &amp; Labrador]</b> <b>When did you travel to Newfoundland &amp; Labrador?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)				
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<b>[If EX02 = Northwest Territories]</b> <b>How many times did you travel to the Northwest Territories since January 1, 2020?</b> _____	<b>[If EX02 = Northwest Territories]</b> <b>When did you travel to Northwest Territories?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<b>[If EX02 = Nova Scotia]</b> <b>How many times did you travel to Nova Scotia since January 1, 2020?</b> _____	<b>[If EX02 = Nova Scotia]</b> <b>When did you travel to Nova Scotia?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<b>[If EX02 = Nunavut]</b> <b>How many times did you travel to Nunavut since January 1, 2020?</b> _____	<b>[If EX02 = Nunavut]</b> <b>When did you travel to Nunavut?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<b>[If EX02 = Ontario]</b> <b>How many times did you travel to Ontario since January 1, 2020?</b> _____	<b>[If EX02 = Ontario]</b> <b>When did you travel to Ontario?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)		
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<p><b>[If EX02 = Prince Edward Island]</b>  <b>How many times did you travel to Prince Edward Island since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = Prince Edward Island]</b>  <b>When did you travel to Prince Edward Island?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Quebec]</b>  <b>How many times did you travel to Quebec since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = Quebec]</b>  <b>When did you travel to Quebec?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Saskatchewan]</b>  <b>How many times did you travel to Saskatchewan since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = Saskatchewan]</b>  <b>When did you travel to Saskatchewan?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Yukon]</b>  <b>How many times did you travel to Yukon since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = Yukon]</b>  <b>When did you travel to Yukon?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Australia]</b>  <b>How many times did you travel to Australia since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = Australia]</b>  <b>When did you travel to Australia?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1" data-bbox="646 338 1414 604"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Caribbean countries]</b>  <b>How many times did you travel to the Caribbean countries since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = Caribbean countries]</b>  <b>When did you travel to the Caribbean countries?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1" data-bbox="646 751 1414 1018"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = China]</b>  <b>How many times did you travel to China since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = China]</b>  <b>When did you travel to China?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1" data-bbox="646 1165 1414 1432"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = France]</b>  <b>How many times did you travel to France since January 1, 2020?</b>          _____</p>	<p><b>[If EX02 = France]</b>  <b>When did you travel to France?</b>  <i>Note: Accepted dates are from Jan 1, 2020 to today's date.</i></p> <table border="1" data-bbox="646 1579 1414 1845"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Germany]</b></p>	<p><b>[If EX02 = Germany]</b></p>												

<p><b>How many times did you travel to Germany since January 1, 2020?</b></p> <p>_____</p>	<p><b>When did you travel to Germany?</b>  <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1" data-bbox="646 302 1414 569"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = India]</b>  <b>How many times did you travel to India since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = India]</b>  <b>When did you travel to India?</b>  <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1" data-bbox="646 716 1414 982"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Iran]</b>  <b>How many times did you travel to Iran since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = Iran]</b>  <b>When did you travel to Iran?</b>  <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1" data-bbox="646 1129 1414 1396"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Italy]</b>  <b>How many times did you travel to Italy since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = Italy]</b>  <b>When did you travel to Italy?</b>  <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1" data-bbox="646 1543 1414 1810"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Mexico]</b></p>	<p><b>[If EX02 = Mexico]</b>  <b>When did you travel to Mexico?</b></p>												

<p><b>How many times did you travel to Mexico since January 1, 2020?</b></p> <p>_____</p>	<p><b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = New Zealand]</b></p> <p><b>How many times did you travel to New Zealand since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = New Zealand]</b></p> <p><b>When did you travel to New Zealand?</b></p> <p><b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = Thailand]</b></p> <p><b>How many times did you travel to Thailand since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = Thailand]</b></p> <p><b>When did you travel to Thailand?</b></p> <p><b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = United Kingdom]</b></p> <p><b>How many times did you travel to the United Kingdom since January 1, 2020?</b></p> <p>_____</p>	<p><b>[If EX02 = United Kingdom]</b></p> <p><b>When did you travel to the United Kingdom?</b></p> <p><b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b></p> <table border="1"> <thead> <tr> <th></th> <th>Return Date</th> </tr> </thead> <tbody> <tr> <td>First trip:</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Second trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Third trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fourth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> <tr> <td>Fifth trip (if applicable):</td> <td>_____ (DD-MM-YYYY)</td> </tr> </tbody> </table>		Return Date	First trip:	_____ (DD-MM-YYYY)	Second trip (if applicable):	_____ (DD-MM-YYYY)	Third trip (if applicable):	_____ (DD-MM-YYYY)	Fourth trip (if applicable):	_____ (DD-MM-YYYY)	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
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<p><b>[If EX02 = United States of America]</b></p>	<p><b>[If EX02 = United States of America]</b></p> <p><b>When did you travel to the United States of America?</b></p>												

<b>How many times did you travel to the United States of America since January 1, 2020?</b> _____	<b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b>	
		Return Date
	First trip:	_____ (DD-MM-YYYY)
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	Fourth trip (if applicable):	_____ (DD-MM-YYYY)
	Fifth trip (if applicable):	_____ (DD-MM-YYYY)
<b>[If EX02 = Other(s)]</b> <b>How many times did you travel to the other provinces or countries specified since January 1, 2020?</b> _____	<b>[If EX02 = Other(s)]</b> <b>When did you travel to the other provinces or countries specified?</b> <b>Note: Accepted dates are from Jan 1, 2020 to today's date.</b>	
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	Fourth trip (if applicable):	_____ (DD-MM-YYYY)
	Fifth trip (if applicable):	_____ (DD-MM-YYYY)

**EX04. How many times have you been in a gathering of 10 or more people since March 2020? Please consider the number of gatherings that occurred indoors and outdoors.**

Number of indoor gatherings: \_\_\_\_\_

Number of outdoor gatherings: \_\_\_\_\_

**EX05. How often have you done the following since March 2020? Please be sure to respond to all the questions.**

*For the last two statements in this list, please use the following definition:*

**Self-quarantine:** did not leave your house or yard due to recent travel, symptoms, positive test, or possible exposure to someone diagnosed with COVID-19.

	Never	Rarely	Occasionally	Often	Always
Wore a mask in public places indoors or where physical distancing was not possible	_	_	_	_	_
Practiced physical	_	_	_	_	_

	Never	Rarely	Occasionally	Often	Always
distancing in public places					
Avoided crowded places/gatherings	_	_	_	_	_
Avoided common greetings (e.g., shaking hands, hugging)	_	_	_	_	_
Limited contact with people at higher risk (e.g., an elderly relative)	_	_	_	_	_
Interacted with a 'cohort family' (another family or small group of close friends who socialize/interact only with each other)	_	_	_	_	_
Taken public transit	_	_	_	_	_
Practiced public health guidelines for handwashing (e.g., wash hands with soap and water for at least 20 seconds)	_	_	_	_	_
Carried hand sanitizer or disinfecting wipes with you when you are outside the house	_	_	_	_	_
Avoided leaving the house for non-essential reasons	_	_	_	_	_
Self-quarantined because you may have been exposed to COVID-19, but	_	_	_	_	_

	Never	Rarely	Occasionally	Often	Always
did not show symptoms					
Self-quarantined because you thought you were infected with COVID-19 and had symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EX06. Has anything about your employment changed because of the pandemic (e.g., working from home)?**

Yes

No → Skip to EX08

**EX07. [If EX06 = 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

**EX08. Since March 2020, have you worked or volunteered in any of the following positions:**

- Hospital or healthcare facility worker (including long term care facilities)
- Health professional in community-based settings (not in hospital)
- Social and community service worker (outside of hospital or healthcare settings; includes services provided in private homes)
- First responder
- Correctional officer
- Other services requiring entry into private homes
- Teacher, school staff and childcare
- Transit/Shuttle driver
- Passenger and delivery drivers (e.g., Taxi, Uber, Limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries)
- Food service industry worker
- Grocery Store Worker
- Casino Worker

- Retail Store Worker
- Hairdresser/Barber
- Aesthetician
- Airline or Airport employee
- Factory Worker
- Farm Worker
- Oil and gas extraction staff

- Yes  
 No → Skip to RF01  
 Prefer not to answer → Skip to RF01

**EX09. [If EX08 = Yes] Which positions have you worked or volunteered in since March 2020?**

**Select all that apply:**

- Hospital or healthcare facility worker (including long term care facilities)
- Health professional in community-based settings (not in hospital)
- Social and community service worker (outside of hospital or healthcare settings; includes services provided in private homes)
- First responder
- Correctional officer
- Other services requiring entry into private homes
- Teacher, school staff and childcare
- Transit/Shuttle driver
- Passenger and delivery drivers (e.g., Taxi, Uber, Limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries)
- Food service industry worker
- Grocery Store Worker
- Casino Worker
- Retail Store Worker
- Hairdresser/Barber
- Aesthetician
- Airline or Airport employee
- Factory Worker
- Farm Worker
- Oil and gas extraction staff

**EX10.**

<p><b>[If selected in EX09]</b>  <b>What was the title for your hospital or healthcare facility worker (including long term care facilities) position?</b>  <b>Select all that apply:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Physician</li> <li><input type="checkbox"/> Dentist</li> <li><input type="checkbox"/> Dental Hygienist and Dental Therapist</li> <li><input type="checkbox"/> Nurse</li> <li><input type="checkbox"/> Physiotherapist/Occupational</li> <li><input type="checkbox"/> Therapist/Allied Health Professional in hospital setting</li> <li><input type="checkbox"/> Medical Imaging Technicians</li> </ul>
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	<input type="checkbox"/> Healthcare Aide <input type="checkbox"/> Environmental Services Worker <input type="checkbox"/> Long term/Nursing Home Care Aide <input type="checkbox"/> Personal Support Worker <input type="checkbox"/> Social Worker <input type="checkbox"/> Dietician <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other Pharmacy worker <input type="checkbox"/> Food Services <input type="checkbox"/> Administrative Worker in healthcare setting <input type="checkbox"/> Other – please specify:_____
<b>[If selected in EX09]</b> <b>What was the title for your health professional in community-based settings (not in hospital) position?</b> <i>Select all that apply:</i>	<input type="checkbox"/> Audiologist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Dietitian <input type="checkbox"/> Family Doctor or Specialist <input type="checkbox"/> Medical Imaging Technicians <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Optometrist or Optician <input type="checkbox"/> Nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other Pharmacy worker <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist or Counsellor <input type="checkbox"/> Speech Language Pathologist <input type="checkbox"/> Other – please specify:_____
<b>[If selected in EX09]</b> <b>What was the title for your social and community service worker (outside of hospital or healthcare settings; includes services provided in private homes) position?</b> <i>Select all that apply:</i>	<input type="checkbox"/> Social Worker <input type="checkbox"/> Personal Support Worker <input type="checkbox"/> Nurse <input type="checkbox"/> Home Care Aide <input type="checkbox"/> Physiotherapist/Occupational Therapist/Allied Health Professional <input type="checkbox"/> Community Aid/Shelter Worker <input type="checkbox"/> Other – please specify:_____
<b>[If selected in EX09]</b> <b>What was the title for your first responder position?</b> <i>Select all that apply:</i>	<input type="checkbox"/> Paramedic <input type="checkbox"/> Firefighter <input type="checkbox"/> Police Officer <input type="checkbox"/> By-Law Officer <input type="checkbox"/> Other – please specify:_____
<b>[If selected in EX09]</b> <b>What was the title for your other services requiring entry into private homes position?</b> <i>Select all that apply:</i>	<input type="checkbox"/> House cleaners <input type="checkbox"/> Movers <input type="checkbox"/> Trades (e.g., plumber, electrician, etc.) <input type="checkbox"/> Other – please specify:_____

<p><b>[If selected in EX09]</b>  <b>What was the title for your teacher, school staff and childcare position?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> Elementary School Teacher/Teacher's Assistant  <input type="checkbox"/> Secondary School Teacher/Teacher's Assistant  <input type="checkbox"/> Post-Secondary School Instructor/Teacher's Assistant  <input type="checkbox"/> Administrative Staff  <input type="checkbox"/> School Facilities Staff  <input type="checkbox"/> Social and Community Service Worker  <input type="checkbox"/> Childcare worker  <input type="checkbox"/> Other – please specify:_____</p>
<p><b>[If selected in EX09]</b>  <b>What was the title for your passenger and delivery drivers (e.g., taxi, Uber, limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries) position?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> Driver (e.g., Taxi, Uber, etc.)  <input type="checkbox"/> Food Delivery (e.g., Skip the Dishes, restaurant deliveries, etc.)  <input type="checkbox"/> Package Delivery (e.g., UPS, FedEx, etc.)  <input type="checkbox"/> Other – please specify:_____</p>
<p><b>[If selected in EX09]</b>  <b>What was the title for your food service industry worker position? Select all that apply:</b></p>	<p><input type="checkbox"/> Food and Beverage server  <input type="checkbox"/> Cashier  <input type="checkbox"/> Cleaning staff  <input type="checkbox"/> Other – please specify:_____</p>
<p><b>[If selected in EX09]</b>  <b>What was the title for your airline or airport employee position? Select all that apply:</b></p>	<p><input type="checkbox"/> Flight Attendant  <input type="checkbox"/> Pilot or Flight Engineer  <input type="checkbox"/> Customer and Information Service Staff  <input type="checkbox"/> Ground Crew  <input type="checkbox"/> Security  <input type="checkbox"/> Customs Officer  <input type="checkbox"/> Cleaning Staff  <input type="checkbox"/> Other – please specify:_____</p>
<p><b>[If selected in EX09]</b>  <b>What was the title for your factory worker position? Select all that apply:</b></p>	<p><input type="checkbox"/> Distribution centre worker  <input type="checkbox"/> Meat packing plant worker  <input type="checkbox"/> Other – please specify:_____</p>
<p><b>[If selected in EX09]</b>  <b>What was the title for your oil and gas extraction staff position? Select all that apply:</b></p>	<p><input type="checkbox"/> Oil rig worker  <input type="checkbox"/> Food worker in camp  <input type="checkbox"/> Cleaning staff in camp  <input type="checkbox"/> Other – please specify:_____</p>

## **RISK FACTORS**

**RF01. At the present time, are you smoking 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)

**RF02. At the present time, are you using electronic cigarettes, also known as an e-cigarettes?**

***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.***

- Daily (At least one e-cigarette every day for the past 30 days)
- Occasionally (At least one e-cigarette in the past 30 days, but not every day)
- Not at all (You did not use e-cigarettes at all in the past 30 days)

**RF03. At the present time, are you using cannabis?**

- Daily (At least once every day for the past 30 days)
- Occasionally (At least once in the past 30 days, but not every day)
- Not at all (You did not use cannabis at all in the past 30 days) → Skip to RF05
- I have never used cannabis → Skip to RF05
- Prefer not to answer → Skip to RF05

**RF04. [If RF03 = Daily OR Occasionally] Which of the following methods to consume cannabis do you use most often?**

- Smoked
- Vaporized
- Consumed in food or drink
- Other
- Prefer not to answer
- Don't know

**RF05. At the present time, how often do you currently 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
- 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. Since March 2020 has a doctor told you that you have a cancer or a malignancy of any kind?**

- Yes
- No → Skip to MC04
- Don't know → Skip to MC04

**MC02. [If MC01 = Yes] What type of cancer?**

**Select all that apply:**

- Bladder
- Brain
- Breast
- Cervix
- Colon
- Esophagus
- Kidney
- Larynx
- Leukemia
- Liver
- Lung and bronchus
- Lymphoma (Hodgkin Lymphoma)
- Lymphoma (non-Hodgkin Lymphoma)
- Mouth, tongue, and throat
- Multiple myeloma
- Ovary
- Pancreatic
- Prostate
- Rectum
- Skin (Melanoma)
- Skin (Non-Melanoma)
- Small intestine
- Stomach
- Testicle
- Thyroid
- Uterus
- Other – please specify: \_\_\_\_\_

**MC03. [If MC01 = Yes] Are you currently undergoing treatment for the cancer or malignancies specified?**

- Yes
- No

Don't know

**MC04. Since March 2020, has a doctor told you that you have any of the following conditions?**

- Diabetes
- Heart and circulatory conditions
- Respiratory system conditions
- Gastrointestinal conditions
- Liver or pancreas conditions
- Renal disease/kidney failure conditions
- Mental health conditions
- Neurological conditions
- Bone and joint conditions
- Skin conditions
- Immune system conditions
- Other condition(s)

Yes

No → Skip to MC07

**MC05. [If MC04=Yes] Which of the following health conditions were you diagnosed with?**

**Select all that apply:**

- Diabetes
- Heart and circulatory conditions
- Respiratory system conditions
- Gastrointestinal conditions
- Liver or pancreas conditions
- Renal disease/kidney failure conditions
- Mental health conditions
- Neurological conditions
- Bone and joint conditions
- Skin conditions
- Immune system conditions
- Other condition(s) – please specify:\_\_\_\_\_

**MC06.**

<b>[If Selected in MC05] Which type of diabetes were you diagnosed with?</b>	<input type="checkbox"/> Type 1 diabetes <input type="checkbox"/> Type 2 diabetes <input type="checkbox"/> Gestational diabetes only
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<p><b>[If Selected in MC05]</b>  <b>Which type of heart and circulatory conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> High blood pressure (hypertension, not including during pregnancy)</li> <li><input type="checkbox"/> High cholesterol</li> <li><input type="checkbox"/> Heart attack (myocardial infarction)</li> <li><input type="checkbox"/> Heart failure</li> <li><input type="checkbox"/> Atherosclerosis / Coronary heart disease (including angioplasty or stents)</li> <li><input type="checkbox"/> Atrial fibrillation</li> <li><input type="checkbox"/> Arrhythmia</li> <li><input type="checkbox"/> Angina</li> <li><input type="checkbox"/> Heart murmur</li> <li><input type="checkbox"/> Valvular heart disease (e.g., aortic stenosis, mitral valve prolapse)</li> </ul>
<p><b>[If Selected in MC05]</b>  <b>Which type of respiratory system conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)</li> <li><input type="checkbox"/> Interstitial lung disease (lung tissue scarring resulting from other health conditions or exposures)</li> <li><input type="checkbox"/> Chronic bronchitis</li> <li><input type="checkbox"/> Cystic fibrosis</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Sleep apnea</li> </ul>
<p><b>[If Selected in MC05]</b>  <b>Which type of gastrointestinal conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Crohn's disease</li> <li><input type="checkbox"/> Ulcerative colitis</li> <li><input type="checkbox"/> Irritable bowel syndrome</li> <li><input type="checkbox"/> Celiac disease</li> <li><input type="checkbox"/> Stomach ulcers</li> <li><input type="checkbox"/> Persistent acid reflux/Gastroesophageal reflux disease (GERD)</li> </ul>
<p><b>[If Selected in MC05]</b>  <b>Which type of liver or pancreas conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Liver cirrhosis</li> <li><input type="checkbox"/> Chronic hepatitis</li> <li><input type="checkbox"/> Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis)</li> <li><input type="checkbox"/> Gallstones</li> </ul>
<p><b>[If Selected in MC05]</b>  <b>Which type of renal disease/kidney failure conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Acute renal failure</li> <li><input type="checkbox"/> Chronic renal failure</li> <li><input type="checkbox"/> Kidney stones</li> </ul>

<p><b>[If Selected in MC05]</b>  <b>Which type of mental health conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> Major depression  <input type="checkbox"/> Minor depression  <input type="checkbox"/> Bipolar disorder  <input type="checkbox"/> Post-traumatic stress disorder  <input type="checkbox"/> Schizophrenia or Schizoaffective disorder  <input type="checkbox"/> Obsessive compulsive disorder  <input type="checkbox"/> Anxiety disorder  <input type="checkbox"/> Eating disorder  <input type="checkbox"/> Addiction disorder (e.g., alcohol, drug or gambling dependence)</p>
<p><b>[If Selected in MC05]</b>  <b>Which type of neurological conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> Thrombotic stroke  <input type="checkbox"/> Hemorrhagic stroke  <input type="checkbox"/> Multiple sclerosis  <input type="checkbox"/> Migraines</p>
<p><b>[If Selected in MC05]</b>  <b>Which type of bone and joint conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> Arthritis  <b>[If Arthritis Selected]</b>  <b>Which type(s) of arthritis was it?</b>  <b>Select all that apply:</b>  <input type="checkbox"/> Rheumatoid arthritis  <input type="checkbox"/> Osteoarthritis  <input type="checkbox"/> Other - please specify: _____  <input type="checkbox"/> Don't know  <input type="checkbox"/> Lupus  <input type="checkbox"/> Fibromyalgia  <input type="checkbox"/> Osteoporosis</p>
<p><b>[If Selected in MC05]</b>  <b>Which type of skin conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> Eczema  <input type="checkbox"/> Rosacea  <input type="checkbox"/> Psoriasis  <input type="checkbox"/> Scleroderma</p>
<p><b>[If Selected in MC05]</b>  <b>Which type of immune system conditions were you diagnosed with?</b>  <b>Select all that apply:</b></p>	<p><input type="checkbox"/> HIV  <input type="checkbox"/> A weakened or compromised immune system (such as Severe Combined Immunodeficiency)  <input type="checkbox"/> Hashimoto's thyroiditis, Sjögren's syndrome, or Ankylosing spondylitis</p>

**MC07. 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 → Skip to PI01
- Medical procedure (e.g., diagnostic or screening) cancelled or deferred → Skip to PI01

- Treatment cancelled or deferred → Skip to PI01
- Other health-related appointment cancelled or deferred (e.g., dental, vision, etc.) → Skip to PI01
- Use of virtual appointments with health care provider → Skip to PI01
- Delayed seeing a healthcare professional about an existing problem or concern
- Delayed seeing a healthcare professional about a new problem or concern
- Delayed routine healthcare service or visit (e.g., procedure, treatment or lab test)
- Regular lab tests cancelled or deferred → Skip to PI01
- Medication shortage → Skip to PI01
- Other – please specify:\_\_\_\_\_ → Skip to PI01
- None or not applicable → Skip to PI01

**MC08 [If MC07 = Any of the Delayed responses] If you delayed pursuing a health service or treatment, what were the reasons?**

**Select all that apply:**

- I was not comfortable seeking health services
- Regular health service provider was not accepting appointments
- I wanted to ensure the health system was available to others who may need it
- I lost my health benefits (e.g., my hours were reduced and/or I was laid off)
- I could not afford to access the services
- Other – please specify:\_\_\_\_\_



## **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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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. Since March 2020, have you accessed mental health services?**

**Select all that apply:**

- No – I did not need it → Skip to DE01
- No – I was not comfortable seeking mental health support → Skip to DE01
- No – My regular mental health professional was not accepting appointments → Skip to DE01
- No – I could not find a new mental health professional that was accepting clients → Skip to DE01
- No – I lost my health benefits (e.g., my hours were reduced and/or I was laid off) → Skip to DE01
- No – I could not afford to access mental health services → Skip to DE01
- Yes – Using resources that I already had in place
- Yes – I have initiated new use of services
- Other – Please specify: \_\_\_\_\_ → Skip to DE01
- Prefer not to answer → Skip to DE01
- Don't know → Skip to DE01

**PI06. [If PI05 = Yes] 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

## **DEMOGRAPHIC INFORMATION**

We ask these questions in every questionnaire as a way to validate the information we are collecting over time.

### **DE01. How old are you?**

\_\_\_\_\_ years

### **DE02. What was your assigned sex at birth?**

- Male
- Female

### **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 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

### **DE06. How many adults (age 18 or older) and children (under 18 years of age) including yourself are currently living in your household?**

**Note: Values between 0-30 accepted. Please use numbers only. Avoid special characters such as “/”.**

- 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

Public health authorities recommend people with at least one COVID-19 symptom stay at home for 14 days. How well people are able to manage this can be affected by the

space available to them where they live. The next two questions are about understanding the capacity to limit your contact with others sharing your home.

**DE07. How many individual bedrooms are in your household?**

Number: \_\_\_\_\_

**DE08. How many individual bathrooms are in your household? Please count all bathrooms, including those with only a sink and a toilet.**

Number: \_\_\_\_\_

**DE09. Has your monthly household income changed because of the COVID-19 pandemic?**

- Substantially decreased
- Somewhat decreased
- No change
- Somewhat increased
- Substantially increased

**DE10. How would you describe your ethnicity or race?**

**Select all that apply:**

- Arab (e.g., Egypt, Iraq, Jordan, Lebanon) → Skip to OT01
- Black (e.g., African or Caribbean descent) → Skip to OT01
- Chinese → Skip to OT01
- Filipino → Skip to OT01
- Indigenous person originating from North America
- Japanese → Skip to OT01
- Korean → Skip to OT01
- Latin American/Hispanic → Skip to OT01
- South Asian (e.g., India, Sri Lanka, Pakistan, Bangladesh) → Skip to OT01
- Southeast Asian (e.g., Malaysia, Indonesia, Vietnam) → Skip to OT01
- West Asian (e.g., Turkey, Iran, Afghanistan) → Skip to OT01
- White (European descent) → Skip to OT01
- Prefer to self-describe – please specify: \_\_\_\_\_ → Skip to OT01
- Prefer not to answer → Skip to OT01

**DE11. [If DE10 = Indigenous person originating from North America] Which of the following groups do you belong to?**

**Select all that apply:**

- First Nations
- Inuit
- Métis
- Non-status First Nations
- Other Indigenous – please specify: \_\_\_\_\_
- Prefer not to answer

**DE12. [If DE10 = Indigenous person originating from North America] Do you live on or off reserve?**

- On-reserve
- Off-reserve
- Prefer not to answer

## OTHER

**OT01. Do you have a family physician/primary care provider?**

- Yes
- No
- Don't Know

**OT02. Did you get a flu shot for the 2020-2021 flu season? Flu shots are generally given from October to March.**

- Yes
- No

**OT03. Are you involved in any other COVID-related studies?**

**Select all that apply:**

- Yes – a vaccine trial
- Yes – experimental treatment(s) (e.g., remdesivir, hydroxychloroquine, etc.)
- Yes – serology/antibody testing (excluding this study)
- Yes - other
- No
- Prefer not to answer

*When this questionnaire was developed, no vaccines were approved for use in Canada.*

**OT04. Is a vaccine to COVID-19 available to you now?**

- Yes
- No → Skip to OT11

**OT05 [If OT04 = Yes] Have you received a vaccine against COVID-19?**

- Yes
- No → Skip to OT11

**OT06. [If OT05 = Yes] Which vaccine did you receive?**

- Pfizer and BioNTech mRNA vaccine
- Moderna mRNA vaccine
- AstraZeneca Oxford vaccine
- Other – please specify: \_\_\_\_\_
- Don't know

**OT07. [If OT05 = Yes] How many doses did you receive?**

- 1
- 2
- 3

**OT08. [If OT07 = 1, 2 OR 3] When did you receive the first COVID-19 dose?**

**Note: Canadian vaccinations began December 14, 2020. If you don't remember the exact date, please choose an approximate date.**

\_\_\_\_\_ (DD-MM-YYYY) → Skip to OT12

**OT09. [If OT07 = 2 OR 3] When did you receive the second COVID-19 dose?**

**Note: Canadian vaccinations began December 14, 2020. The date entered must be later than, or the same as, the date of your first dose. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.**

\_\_\_\_\_ (DD-MM-YYYY) → Skip to OT12

**OT10. [If OT07 = 3] When did you receive the third COVID-19 dose?**

**Note: Canadian vaccinations began December 14, 2020. The date entered must be later than, or the same as, the date of your second dose. If you don't remember exactly when, please choose an approximate date. Respond to all questions on this page before clicking 'Next Page'. Your response will register when the 'Next Page' button is clicked.**

\_\_\_\_\_ (DD-MM-YYYY) → Skip to OT12

**OT11 [If OT04 = No OR OT05 = No] Would you be willing to take a vaccine if/when one becomes available?**

- Yes
- No
- Don't know

The following questions may help interpret results from the analysis of the blood spot sample you will provide.

**OT12. Have you received a blood transfusion in the past 2 months?**

- Yes
- No

**OT13. Have you received chemotherapy in the past 3 months?**

- Yes
- No

**OT14. Have you received radiotherapy treatment in the last 3 months?**

- Yes
- No

**OT15. 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

**OT16. How much do you weigh?**

- ***If you have a scale, 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.***
- ***If you don't have a scale, please estimate your current weight.***

Pounds \_\_\_\_\_

Kilograms \_\_\_\_\_

Prefer not to answer

Don't know

**Click *Finish* to submit this questionnaire.**