CANPATH COVID-19 QUESTIONNAIRE SUMMARY TABLE

Ontario Health Study / Étude sur la santé Ontario	First Timepoint	Second Timepoint	Third Timepoint	For access inquiries, please contact access@ontariohealthstudy.ca
Years in Use	Feb-Oct 2021	Sep 2021-Jul 2022	Mar 2022-Jan 2023	NOTES
COVID-19 DIAGNOSIS	✓	✓		
Do you think you currently have COVID-19 (Why)	✓	✓**	✓***	** Since January 1, 2021 *** Since September 1, 2021
Had contact with someone who tested positive for COVID-19: -When -Who was the person	✓	✓**	✓	
Have you been tested for COVID-19 (rapid test, nasal swab and/or blood testing); How many times (For each test: type of test, date of test, the result) A maximum of 8 tests can be reported	✓	✓**	✓**	** Include Rapid test
COVID-19 CARE/HOSPITAL RELATED INFORMATION	✓	✓		
Hospitalized because of COVID-19 (Date of admission, number of days in hospital)	✓	✓*	✓***	* Since January 1, 2021 *** Since September 1, 2021
Date of admission	✓	✓		
Number of days in hospital	✓	✓		
Admitted to an intensive care unit	✓	✓		
How long did you stay in the intensive care unit	✓	✓		
Continue to experience COVID-19 symptoms or complications related to hospitalization after you were discharged	✓	✓		
COVID-19 SYMPTOMS	✓	✓		
Experienced any of the following symptoms, Severity: Fever >38°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	✓*	✓**	✓***	* Since January 1, 2020 ** Since January 1, 2021 *** Since September 1, 2020,
When did you first experience these symptoms?	✓*	✓**	✓***	* Since January 1, 2020 ** Since January 1, 2021 *** Since September 1, 2020,
When did you experience the most recent symptoms?	✓*	✓**	✓***	* Since January 1, 2020 ** Since January 1, 2021 *** Since September 1, 2020,
While having symptoms, did you have close contact with any of the following people: -Spouse or partner -Family members living in the same place -Family members living in another place -Housemates -Friends -Work colleagues	✓*	✓**	✓***	* Since January 1, 2020 ** Since January 1, 2021 *** Since September 1, 2020,
Has any of those person(s) developed COVID-related symptoms, If yes what is your relationship & number of persons	✓*	✓**	✓***	* Since January 1, 2020 ** Since January 1, 2021 *** Since September 1, 2020,
Do you continue to experience COVID-19 symptoms	✓*	✓**	✓***	* Since January 1, 2020 ** Since January 1, 2021 *** Since September 1, 2020,
COVID-19 EXPOSURE	✓			
Did you travel outside your home province (What province or country, How many times-up to five trips, Date)	✓*			* Since January 1, 2020
How many times have you been in a gathering of 10 or more people	✓*			* Since March 2020
How often have you:	✓*			* **Since March 2020**
Worn a mask in public places indoors or where physical distancing was not possible	✓*			
Practiced physical 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	✓*			

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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 did not show symptoms	✓*			
Self-quarantined because you thought you were infected with COVID-19 and had symptoms	✓*			
EMPLOYMENT	✓			
Has anything about your employment changed because of the pandemic (e.g., working from home)? What has changed	✓			
Have you worked or volunteered in, Which positions: Hospital or healthcare facility worker, Health professional in community-based settings, Social and community service worker, First responder, Correctional officer, Teacher, school staff and childcare, Transit/Shuttle driver, Passenger and delivery drivers, Food service industry, Grocery Store, Casino, Retail Store, Hairdresser/Barber, Aesthetician, Airline or Airport, Factory, Farm, Oil and gas extraction	✓*			* Since March 2020
LONG COVID			✓	**The following questions aim to capture longer lasting symptoms and impacts.**
Have you ever had a COVID-19 infection			✓	
When did you have COVID-19			✓	Please focus your answers on the longest episode of illness you have experienced
How long have you had / did you have COVID-19 symptoms overall			✓	
Have you experienced any of the following symptoms for more than 1 month after infection, Severity: Headache, Chronic Fatigue, Fever >38°C, Shortness of breath or difficulty breathing, Persistent cough, Muscle aches/pains or weakness, Loss of smell or taste, Memory problems (e.g. brain fog, difficulty concentrating), Mental health concerns (e.g. anxiety, depression), Difficulty sleeping, Heart problems (e.g. chest pain, fast heartbeat), Gastrointestinal upset (e.g. nausea, diarrhea), Other			✓	
How much do you feel fully recovered from COVID-19			✓	
Assess the impact of your COVID-19 infection on your: Personal activities (e.g., grocery shopping, gardening), Family life, Professional life, Social life, Morale/mood, Relationship with caregivers			✓	
RISK FACTORS	✓	✓	✓	
At the present time, smoking cigarettes daily, occasionally, or not at all	✓	✓	✓	
At the present time, using electronic cigarettes	✓	✓	✓	
At the present time, using cannabis, methods to consume cannabis	✓	✓	✓	
At the present time, how often do you currently drink alcohol	✓	✓	✓	
MEDICAL CONDITIONS	✓		✓	
Has a doctor told you that you have a cancer. Type, Currently undergoing treatment for the cancer	✓*		✓***	* Since March 2020 *** Since March 2021

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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**	✓*		✓***	* Since March 2020 *** Since March 2021
Have you experienced any change to access to health services	✓*		✓***	* Since March 2020 *** Since March 2021
If you delayed pursuing a health service or treatment, what were the reasons	✓*		✓***	* Since March 2020 *** Since March 2021
MENTAL & EMOTIONAL IMPACTS		✓		
How often have you been bothered by: **•Feeling nervous, anxious, or on edge** **•Not being able to stop or control worrying** **•Worrying too much about different things** **•Trouble relaxing** **•Being so restless that it's hard to sit still** **•Becoming easily annoyed or irritable** **•Feeling afraid as if something awful might happen**	✓*	✓**	✓***	* Since March 2020 ** Since January 2021 when COVID-19 was declared a pandemic *** Since September 2021
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	✓*	✓**	✓***	* Since March 2020 ** Since January 2021 when COVID-19 was declared a pandemic *** Since September 2021
How often have you been bothered by: **•Little interest or pleasure in doing things** **•Feeling down, depressed or hopeless** **•Trouble falling or staying asleep, or sleeping too much** **•Feeling tired or having little energy** **•Poor appetite or overeating** **•Feeling bad about yourself, or that you are a failure, or have let yourself or your family down** **•Trouble concentrating on things, such as reading the newspaper or watching television** **•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**	✓*	✓**	✓***	* Since March 2020 ** Since January 2021 when COVID-19 was declared a pandemic *** Since September 2021
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	✓*	✓**	✓***	* Since March 2020 ** Since January 2021 when COVID-19 was declared a pandemic *** Since September 2021
Have you accessed mental health services?	✓*		✓***	* Since March 2020 *** Since September 2021
OTHER/VACCINES & SIDE EFFECTS***		✓**	✓***	
Is a vaccine to COVID-19 available to you now?	✓	✓		
Would you be willing to take a vaccine if/when one becomes available?	✓	✓		
Have you received a vaccine against COVID-19?	✓	✓	✓	
Where did you receive this vaccine (province, state or country)		✓		
If you have not received a vaccine yet, how likely are you to get one in the future?			✓	
Type of vaccine: **•Pfizer and BioNTech mRNA vaccine** **•Moderna mRNA vaccine** **•AstraZeneca Oxford / Covishield vaccine** **•Janssen (Johnson & Johnson) vaccine** **•Other – please specify (open text)**	✓*	✓	✓	* Does not include Janssen (Johnson & Johnson) vaccine

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How many doses	✓*	✓**	✓***	* Max 3 doses ** Max 4 doses *** Max 6 doses
Date of receiving vaccine	✓*	✓	✓	
In what setting did you receive the vaccine: •Hospital •Public health clinic •Pharmacy •Nursing station •Physician office •Long-term care home •Workplace clinic •Other – please specify (open text)		✓	✓	
Experience any side-effects (within the first few days) after receiving any dose of the COVID-19 vaccine		✓	✓	
Experience the following side-effects in the arm where you had the needle, Severity: •Redness •Itching/hives •Prickling/tingling •Soreness •Pain •Swelling •Bruising		✓		
Experience any of the following side-effects, Severity: Fatigue, Headache , Fever >38°C, Chills or shivering, Muscle aches/pains, Sore throat, Difficulty swallowing, Shortness of breath or difficulty breathing, Wheezing, Chest pain, Fast heartbeat, Blurry vision, Dizziness or light-headed, Abdominal pain, Nausea, Vomiting, Diarrhea, Rash, redness, or hives on other places on your body (other than the arm where you had the needle), Swelling of other places on your body (other than the arm where you had the needle), Numbness (in places of your body other than the arm where you had the needle), Prickling or tingling (in places of your body other than the arm where you had the needle)		✓	✓	
Did you experience any other side-effects		✓	✓	
Which dose did you experience these other side effects?			✓	
Did you contact a healthcare provider about Mild/Moderate/Severe symptoms		✓	✓	
Did you require hospitalization for Mild/Moderate/Severe symptoms		✓	✓	
How long did Mild/Moderate/Severe symptoms last		✓	✓	
Main concerns you have around getting the vaccine		✓	✓	
Main reasons for getting the vaccine		✓		
Have you received a blood transfusion in the past 2 months	✓	✓	✓	
Have you received chemotherapy in the past 3 months	✓	✓	✓	
Have you received radiotherapy treatment in the last 3 months	✓	✓	✓	
OTHER			✓	

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Have you worked or volunteered in any of the following positions? Which 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**			✓*	* Since March 2021
Prior to the pandemic, what was your approximate total household income			✓	
Has your monthly household income been changed because of the COVID-19 pandemic	✓		✓	
Have your household savings been changed because of the COVID-19 pandemic			✓	
Describe the impact of COVID-19 on your ability to meet financial obligations or essential needs, such as rent or mortgage payments, utilities and groceries			✓	
ANTHROPOMETRICS			✓	
Height	✓		✓	
Weight	✓		✓	
DEMOGRAPHIC INFORMATION	✓			
Age	✓			
Sex	✓			* Sex at birth ** Current sex
Gender you currently live as in your day-to-day life	✓			
The first three digits of your current residential Postal Code	✓			
Numer of adults and children including are currently living in your household	✓			
Numer of individual bedrooms in your household	✓			
Numer of individual bathrooms in your household	✓			
Ethnicity or Race	✓			
For Indigenous person: **1-Which of the following groups do you belong to** **2-Do you live on or off reserve**	✓			
OTHER	✓			
Do you have a family physician/primary care provider	✓			
Did you get a flu shot for the 2020-2021 flu season	✓			
Are you involved in any other COVID-related studies	✓			