These surveys are confidential and will not be shared with any entity outside of the research program. Specifically, they will not be shared with employers, health insurance providers, legal entities, or any other third party.	
Reference questions	Responses
Questions about you	
1- What is your date of birth?	mm/dd/yyyy
2- What is your gender?	Female Male Gay Lesbian *Queer* Bisexual Transgender female Transgender male Fluid or non-binary
2a- Do you currently have menstrual periods?	Yes No
2b- Are you currently using a birth control method to prevent pregnancy?	Yes No
2c- To your knowledge, are you pregnant?	Yes No
3- What is your race? Mark all that apply.	Native of Alaska or American aborigine Asian Negro (or Afro-American) Native of Hawaii or another Pacific island White (or Caucasian) Other
3a- If you are Asian, what heritage do you identify with?	Central/South Asian heritage Japanese heritage East Asian heritage Southeast Asian heritage
4- Do you belong to the Hispanic or Latin ethnic group?	Yes No

5- What is your approximate height without shoes?	_____ feet _____ inches
6- What is your approximate weight without shoes?	____ pounds
7- What is your marital status?	Single Married Common-law partner Divorced Widowed
8- What is your highest level of education?	Secondary school without graduating Secondary school graduate College without graduating College graduate Post-graduate degree Other, please specify:
9- Are you currently employed and receiving a salary? Choose the option that best describes you.	I am currently working and receiving a salary. I do not work for pay. I am not working or looking for work. I do volunteer work. I receive disability payments.
9a- Where do you work?	I work only from home. I work only outside of my home. I work partly from home and partly outside of my home.
9b- We would like to know whether your occupation is high-risk. If it is, mark the occupation in which you currently work.	I do not currently have a job. I do not work in any of the occupations listed below. I work in the following areas or positions: Healthcare area Lawyer, accountant, stock broker, insurance agent Administrative personnel Teacher: preschool or kindergarten through the last year of secondary school Police Firefighter Emergency medical technician Hospitality and leisure personnel: restaurants/hotels Food processing personnel Retail sales personnel Bricklaying

	Manufacturing Other essential worker
9c- In the past few months, how often have you left your home to do activities that involve contact with other people? Think of work, school, public transportation; religious, social, leisure, and other activities.	Daily A few times a week A few times a month Less than once a month Never
9d- In total, approximately how much time do you dedicate to these activities with other people?	For these activities: Hours per week: _____
10- What is your family group's total annual income from all sources?	Less than $25,000 per year $25,000 to $50,000 per year $50,000 to $100,000 per year More than $100,000 per year
11- What is your current housing situation?	Own your own house or apartment. Rent a house or apartment. Live with your family. Live in a group home. Share the house with relatives or others. Live in a residential institution. Live in a rest home. Other, please specify:
12- Do you have health insurance?	Yes No
12a- What type of health insurance do you have? Mark all that apply.	Private Medicare Medicaid Public assistance Tricare or another military plan
13- Where do you receive advice or information about your health from? Mark all that apply.	Medical staff Family Friends Religious institution Internet Cable TV

	Other, please specify:
14- Which of the following are available to you? Mark all that apply.	"Smart" phone Tablet Laptop computer Desktop computer E-mail address None of the above
15- Who would you call if you had a medical emergency? Mark all that apply.	Family Friends Police Fire department 911 Neighbor Other, please specify:
16- What languages are spoken in your household? Mark all that apply.	English Spanish French Italian German Chinese Japanese Hindi Farsi Russian Korean Vietnamese Other, please specify:
17- How many people normally live in your house, including you?	1 2 3 4 5 6 More than 6
17a- What are the ages of the other people who live in your house? Respond only for a maximum of 6 people.	Person No. 1 _____ Person No. 2 _____ Person No. 3 _____ Person No. 4 _____ Person No. 5 _____ Person No. 6 _____

GENERAL HEALTH QUESTIONS

18- Consider only the last 7 days and rate each symptom you have had (if you had any) at its worst point worst [sic] and indicate how long each symptom lasted.

- **None**: I did not have any symptoms
- **Mild**: The symptom did not last long, did not require any special treatment, and did not affect my daily activities.
- **Moderate**: The symptom caused mild concern and some minor changes in my daily activities, but it was relieved with simple remedies (for example, a headache that goes away after taking a nap).
- **Severe**: The symptom interrupted my usual daily activities and required medications or other medical treatment (for example, a migraine that lasted several hours and required prescription medication).

Symptom	None	Mild	Moderate	Severe	Duration
Congested or runny nose					Minutes: Hours: Days:
Sore throat					Minutes: Hours: Days:
Cough					Minutes: Hours: Days:
Low energy or fatigue					Minutes: Hours: Days:
Muscle or body pain					Minutes: Hours: Days:
Headache					Minutes: Hours: Days:
Chills or tremors					Minutes: Hours: Days:
Nausea					Minutes: Hours: Days:
Difficulty breathing					Minutes: Hours: Days:

18a- In this table, select the box that shows how many times (if any) you had **vomiting or diarrhea** (soft

Symptom	None	1 or 2 times	3 or 4 times	More than 5 times
Vomiting				

<table>
<tr><td>or watery stools) in the last 7 days.</td><td><table><tr><td>Diarrhea</td><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>18b- In this table, select the box that best describes the changes (if any) in your senses of smell and taste during the past 7 days.</td><td><table><tr><td></td><td>Same as usual</td><td>Less than usual</td><td>More than usual</td></tr><tr><td>Smell</td><td></td><td></td><td></td></tr><tr><td>Taste</td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td></td><td></td></tr>
<tr><td>19- In the past 6 months before your enrollment in the Evusheld™ study did any of the people who live in your house have a positive result for COVID-19 infection?</td><td>Yes
No</td></tr>
<tr><td>19a- How many people had a positive COVID result?</td><td>1
2
3
4
5
6
More than 6</td></tr>
<tr><td>19b- In the last 6 months prior to your enrollment in the Evusheld™ study, did any of your family members have to be quarantined to protect you from a COVID-19 infection?</td><td>Yes
No</td></tr>
<tr><td>19c- How long did the quarantine last?</td><td>1 to 3 days
4 to 6 days
7 or more days
I live alone</td></tr>
<tr><td></td><td></td></tr>
<tr><td>20- During the past month, how many people who live in your house worked outside of the home?</td><td>0
1
2
3
4
5
6
More than 6</td></tr>
<tr><td></td><td></td></tr>
</table>

21- How many of the people who live in your house work in social or healthcare services (e.g., nurse, doctor, healthcare staff, social worker)?	0 1 2 3 4 4 6 More than 6
22- How many children who live in your house (0-18 years old) attend a school or day care outside of the home?	0 1 2 3 4 5 6 More than 6
23- In the last month, how often did you leave your house to visit friends or family?	Daily A few times a week A few times a month Once a month Never Other: Explain.
24- In the last month, how often did you have visitors (friends, family, caregivers, cleaning people, or others)?	Daily A few times a week A few times a month Once a month Never Other: Explain.
25- In the past month, how often did you leave your house to buy food or other items?	Daily A few times a week A few times a month Once a month Never Other: Explain.
26- Have you been vaccinated against COVID-19?	Yes No
26a- When did you receive your first dose of the COVID-19 vaccine? (Use the date shown on	mm/dd/yyyy If you aren't sure, enter the approximate date (mm/dd/yyyy)

your COVID-19 vaccination card).	
26b- What vaccine did you receive in your first dose?	Moderna Pfizer Janssen (J&J) Other, specify the manufacturer: I don't know
27- When did you receive a 2nd dose of the COVID-19 vaccine?	I did not receive one. Date when I received it (mm/dd/yyyy) If you aren't sure, enter the approximate date (mm/dd/yyyy)
27a- What vaccine did you receive in your second dose?	Moderna Pfizer Janssen (J&J) Other, specify the manufacturer: I don't know
28- When did you receive a third dose or "booster" of the COVID-19 vaccine?	I did not receive one. Date when I received it (mm/dd/yyyy) If you aren't sure, enter the approximate date (mm/dd/yyyy)
28a- What vaccine did you receive?	Moderna Pfizer Janssen (J&J) Other, specify the manufacturer: I don't know
29- When did you receive a fourth dose or "booster" of the COVID-19 vaccine?	I did not receive one. Date when I received it (mm/dd/yyyy) If you aren't sure, enter the approximate date (mm/dd/yyyy)
29a- What vaccine did you receive?	Moderna Pfizer Janssen (J&J) Other, specify the manufacturer: I don't know
30- When did you receive a fifth dose or "booster" of the COVID-19 vaccine?	I did not receive one. Date when I received it (mm/dd/yyyy) If you aren't sure, enter the approximate date (mm/dd/yyyy)
30a- What vaccine did you receive?	Moderna Pfizer Janssen (J&J) Other, specify the manufacturer: I don't know

31- Have you ever had a positive result for COVID-19?	Yes No
31a- On what date did you take that test?	mm/dd/yyyy If you aren't sure, enter the approximate date (mm/dd/yyyy)
31b- What type of test was it? Mark all that apply.	Home test Rapid test PCR test I don't know
31c- If you had a positive result on a home test or rapid test, did-you confirm it with a PCR test?	Yes No I don't know
31d- Where was the PCR test done?	Pharmacy Laboratory Urgent care center Walk-in clinic Doctor's office Emergency room Hospital Testing center Test done at home by medical personnel I don't know
32- In the past 4 weeks, did you have contact with anyone who may have had a positive result for COVID-19?	Yes No I don't know
QUESTIONS ABOUT YOUR CANCER	
33- Indicate the type of cancer for which you are currently being treated or for which you have been treated in the past 12 months. Mark all that apply.	Acute myeloid leukemia (AML) Chronic myeloid leukemia (CML) Acute lymphocytic leukemia (ALL) Chronic lymphocytic leukemia (CLL) Multiple myeloma (MM) Hodgkin's lymphoma Non-Hodgkin's lymphoma (B-cell lymphoma) Myelodysplastic syndrome (MDS) Polycythemia vera (P-Vera) Myelofibrosis Essential thrombocytemia

	Waldenström macroglobulinemia Breast cancer Lung cancer Thyroid cancer Prostate cancer Colon cancer Ovarian cancer Pancreatic cancer Kidney or renal cell cancer Bladder cancer Liver cancer Stomach cancer Esophageal cancer Throat cancer Malignant melanoma Other
34- When did your doctor or other healthcare professional FIRST tell you that you had cancer?	Less than 1 month ago 1–6 months ago 7–12 months ago More than 1 year but less than 3 years ago More than 3 years ago
35- Have you ever had surgery to remove all or part of the cancer?	Yes No
36- Are you currently receiving radiation or proton therapy to treat cancer?	Yes No
37- According to what your doctor says, how is the cancer is [sic] currently? Select one option.	In remission (there is no cancer present now) Stable Progressing
38- In addition to cancer, do you have any other medical problem for which you are currently being treated? If so, mark all that apply.	I do not have another medical problem. Obesity High cholesterol or triglycerides Diabetes Chronic obstructive pulmonary disease, asthma, bronchitis Sleep apnea

	Hypertension Heart failure Chest pain, unstable angina, or coronary arteriopathy Atrial fibrillation Stroke Peripheral vascular disease Confusion Depression Pain HIV Renal failure Rheumatoid arthritis Systemic lupus erythematosus Organ transplant Other: Please specify_____
39- Have you been hospitalized in the past two years? If so, mark all the conditions that apply.	**I have not been hospitalized** in the past two years. Diabetes Pneumonia Heart attack Heart failure Chest pain or unstable angina Chronic obstructive pulmonary disease, asthma, bronchitis Stroke Atrial fibrillation Gastrointestinal bleeding Renal failure Confusion HIV Other: Please specify_____

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