Monthly Follow-up Questions	Answers
QUESTIONS ABOUT YOU	
1. Since the last survey, how often have you left your home to do activities in close contact with other people? Think about work, school, public transportation, religious activities, shopping, social activities, recreation and other activities.	Daily A few times per week A few times per month Less than once per month Never
2. In total, how much time do you approximately spend engaging in these activities with other people?	For these activities: Hours per week: _____
3- Since the last survey, how frequently did you have visitors (friends, relatives, caregivers, cleaning staff or others)?	Daily A few times per week A few times per month Less than once per month Never
QUESTIONS ABOUT COVID	
4- Since the last survey, have you been in contact with anyone who does not live with you and received a positive COVID-19 test result?	Yes No
4a- When did you have contact with this person?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
4b- Did you test yourself at home for COVID-19 as a result of that contact?	Yes No
4c- When did you take the test?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
4d- Which was the test result?	Positive Negative
4e- Did you take a COVID-19 PCR test?	Yes No

4f- When did you take the PCR test?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
4g- Which was the result of the PCR test?	Positive Negative
5- Since the last survey, did anyone who lives in your home test positive for COVID-19?	Yes No
5a- When did this person who lives in your home test positive for COVID-19?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
5B- Did you take a **home** COVID-19 test as a result of this exposure?	Yes No
5c- When did you take the test?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
5d- What was the result of the test?	Positive Negative
5e- Did you take a COVID-19 PCR test?	Yes No
5f- When did you take the PCR test?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
5g- What was the result of the PCR test?	Positive Negative
6- Since the last survey, have you had to quarantine to avoid entering into contact with someone who lives in your home due to a COVID infection?	Yes No
6a- How long were you in quarantine?	1-3 days 4-6 days More than 7 days Never I live alone
7- Since the last survey, have you had a body temperature over 99.5 degrees Fahrenheit?	Yes No

7a- Indicate the date the fever began.	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).

8- Since the last survey, have you had a change in your health or any new symptoms? Classify each symptom (if you had any) at its worst point since **the last survey** using the definitions below to indicate its severity.

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

Symptom	None	Slight	Moderate	Serious	Duration
Stuffy or runny nose					Minutes: Hours: Days:
Sore throat					Minutes: Hours: Days:
Cough					Minutes: Hours: Minutes:
Tiredness or fatigue					Minutes: Hours: Days:
Muscle, body or joint pain					Minutes: Hours: Days:
Headache					Minutes: Hours: Days:
Chills or shivering					Minutes: Hours: Days:
Difficulty breathing					Minutes: Hours: Days:
Stomach pain					Minutes: Hours: Days:
Decreased appetite					Minutes: Hours: Days:
Confusion or brain fog					Minutes: Hours: Days:
Hives, swollen tongue, difficulty swallowing					Minutes: Hours: Days:
Rash					Minutes: Hours: Days:
Weakness or general malaise					Minutes: Hours: Days:

8a- Choose the box in this table that shows how many times (if applicable) you had **vomiting or diarrhea** (loose or watery stools) since the last survey.

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

8b- Choose the box in this table that shows how many times (if applicable)

	Same as usual	Less than usual	No changes
Smell			
Taste			

you had changes in your senses of **smell or taste** since the last survey.	
9- Did you take any medication to alleviate any of the aforementioned symptoms?	Yes No
9a- What did you take?	Medication name: _____
9b- Did you take a home COVID-19 test due to any of these symptoms?	Yes No I did not have a home test kit
9c- Which was the result of your home COVID-19 test?	Positive Negative
9d- When did you take the home COVID-19 test?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
9e- If the home test result was positive or you did not have a test kit, did you take a PCR test?	Yes No
9f- Where did you take the PCR test?	Pharmacy Laboratory Doctor's office Urgent care center Emergency room Hospital Testing center Other location: _____
9g- Which was the result of the PCR test?	Positive Negative
9h- When did you take the PCR test?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
9i- Did you inform your oncologist of the test result?	Yes No
9j- What treatment did your oncologist recommend?	Staying at home Going to the hospital Taking oral medications Other: _____
9j- Did you have blood drawn for special tests at your oncologist's office?	Yes No Not yet
10- Compared to before testing positive for COVID-19, have you returned to your usual state of health?	I returned to my usual state of health. I returned but to a poorer-than-usual state of health I did not return to my usual state of health

11- Compared to the activities that you engaged in prior to testing positive for COVID-19, have you returned to your regular activities?	I have returned to my regular activities I have returned to some of my regular activities I have not returned to my regular activities
12- Have there been any changes in your symptoms since you received a positive COVID-19 test result?	No changes Some are the same and others worsened Some are the same and others improved Some are the same and others disappeared They all disappeared
13- Since the last survey, how many days were you absent from work for a health-related reason?	0 1 2 3 4 5 or more
14- Since the last survey, were you prevented from performing any of your daily activities due to health problems?	Yes No
14a- Which activities were you unable to perform?	Activities: _____
15- Since the last survey, have you received treatment for a positive COVID-19 infection?	Yes No
15a- When did you test positive?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
15b- When did you begin treatment?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
15c- What medication did you receive to treat the infection? Select the name of the medication manufacturer.	AstraZeneca Regeneron Eli Lilly GSK Merck Pfizer Other
16- Since the last survey, have you	Yes

received an additional dose of a COVID-19 vaccine?	No
16a- Which vaccine did you receive?	Moderna Pfizer Janssen Other
QUESTIONS ABOUT YOUR HEALTH	
17- Since the last survey, have there been any changes to your medications that are not for cancer? This includes changes in dose or frequency of your medication(s).	Yes No
17a- Please specify.	Medication name: _____ Dose: _____ Times per day: _____
18- Since the last survey, have you had any changes in the dose or frequency of any of your cancer medications?	Yes No I am not taking medication for cancer.
18a- Please specify.	Medication name: _____ Dose: _____ Times per day: _____
19- Since the last survey, how is your cancer currently, according to your doctor? Select one option.	In remission (no cancer present now) Stable In progression I don't know
20- Since the last survey, have you been told that you need to start a new treatment, change your current treatment, or resume a treatment you stopped? Mark all that apply.	I have to start a new medication and/or radiation or proton therapy I have to change my medication and/or radiation or proton therapy I need to restart my medication and/or radiation or proton therapy I do not need to change my treatment
21- Since the last survey, have you developed any new medical conditions?	Yes No
21a- Please specify.	Conditions: _____
22- Since the last survey, have there been any changes to your physical	Better Worse

condition?	No changes
23- Since the last survey, have you had any change in your feeling of wellbeing?	Better Worse No changes
24- Since the last survey, have you gone to an emergency room, to a doctor's office for an unscheduled visit, to an urgent care center, had a virtual medical visit, or been hospitalized for at least one night?	Yes No
24a- What is the name of the facility or virtual visit service where you received treatment?	Name: _____
24b- When did you arrive at the institution or begin the virtual visit where you received treatment?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
24c- Why did you go to that facility or attend that virtual visit?	Didn't feel well Fever Cough Concern over COVID-19 Difficulty breathing Sore throat Other
24d- Did you have any blood tests or X-rays?	Yes No
24e- Which were the results of the X-rays or blood tests?	The results were: _____ I do not have the results
24f- Were you given intravenous fluids or medications to treat your problem?	Yes No
24g- Do you remember the names of the medications you were given?	Name(s) _____ Don't know
24h- When were you released from the urgent care center, doctor's office, emergency room or hospital, or when did the virtual visit end?	mm/dd/yyyy If you are not sure, enter the approximate date (mm/dd/yyyy).
23i- After you were released or the virtual visit ended, what happened to your symptoms?	They were resolved (completely went away) They were partially resolved (slightly improved) They were not resolved (did not improve at all) They got worse
24- Since the last survey, when you were with people who were not	More discomfort The same discomfort

vaccinated against COVID-19, did you feel a greater, lesser or equal level of discomfort compared to before?	Less discomfort