

**NorFlu COVID-19 (all questions)**

**og**

**MoBa COVID-19 (questions 1-16)**

This simple form will take approximately 5 minutes to complete.  
The main purpose is to understand the prevalence of coronavirus disease.  
Participation is completely voluntary.

ScheduleID (do not change this):

**1. Have you become ill with respiratory symptoms, illness or fever within the last 14 days ?**

No

Yes

*Questions 1.1 - 1.15. appears only if the option "Yes" is selected in the question " 1. Have you become ill with respiratory symptoms, illness or fever within the last 14 days ?"*

**1.1. How many days has it been since the illness / symptoms began?**

0-1 day

2-3 days

4-5 days

6-7 days

8-9 days

10-14 days

**1.2. Check *how sick* you felt:**

Not very ill

Quite ill, in bed for several days

Very ill

**1.3. Check *how long* you felt sick:**

1-2 days

3-5 days

6 days or more

Do not know

**1.4. Check *when* you felt the sickest:**

1-2 days after symptom(s) onset

3-5 days after symptom(s) onset

6 days or more after symptom(s) onset

Do not know

**1.5. Are you still coughing?**

No

Yes

*This question appears only if the option "Yes" is selected in the question "1.5. Are you still coughing? "*

**Do you have a dry cough or do you produce mucus?**

Dry Cough

Cough with mucus

**1.6. Do you still have a runny nose or are you sneezing?**

No

Yes

**1.7. Do you still have a stuffy nose/nasal congestion?**

No

Yes

**1.8. Do you still have a sore throat?**

No

Yes

*This question appears only if the option "Yes" is selected in the question "1.8. Do you still have a sore throat? "*

**Is it painful to swallow?**

No

Yes

**1.9. Do you still have tightness in your chest (heavy breathing)?**

No

Yes

**10.1. Have you had a headache today or in the last 3 days ?**

No

Yes

**11.1. Have you had a fever today or in the last 3 days ?**

No

Yes

*This question appears only if the option "Yes" is selected in the question "1.11. Have you had a fever today or in the last 3 days? "*

**Have you felt very cold (trembling) or experienced severe sweating?**

No

Yes

**12.1. Have you had stomach pain / nausea / diarrhea today or in the last 3 days ?**

No

Yes

**1.13. Have you had a decreased sense of smell or taste in the last 3 days ?**

No

Yes

**1.14. Have you had muscle pain in the last 3 days ?**

No

Yes

**1.15. Have you experienced dizziness in the last 3 days ?**

- No
- Yes

**2. Have you been examined by / had a consultation with a doctor (eg telephone) during the last 14 days ?**

- No
- Yes

*This question appears only if the option "Yes" is selected in the question "2. Have you been examined by / had a consultation with a doctor (eg telephone) during the last 14 days ? "*

**Check if you have any of the following diagnoses, or no diagnosis:**

- Suspected or confirmed coronavirus disease
- Suspected or confirmed influenza
- Pneumonia
- Sore throat
- Cold
- Other infection
- Injury
- Other illness
- No diagnosis

**3. Have you been hospitalized in the last 14 days ?**

- No
- Yes

**4. Have you been tested for a corona or influenza virus infection in the last 14 days ?**

- No
- Yes
- Do not know

*These questions appear only if the option "Yes" is selected in the question "4. Have you been tested for a corona or influenza virus infection within the last 14 days ? "*

**Did the test show that you had a coronavirus infection?**

- No
- Yes
- Do not know

**Did the test show that you had an influenza virus infection?**

- No
- Yes
- Do not know

**5. Have you been in quarantine / isolation in the last 14 days ?**

- No
- Yes

*This item appears only if the option "Yes" is selected in the question "5. Have you been in quarantine / isolation in the last 14 days ? "*

**Check why you have been quarantined / isolated:**

- Have been abroad
- Had symptoms of illness
- Confirmed coronavirus infection
- Was in contact with people who are infected
- Another reason

**6. Check if you have any of the following diseases:**

- Asthma or other lung disease
- Cancer
- Heart disease
- Diabetes
- High blood pressure
- Other illness
- Has no illness

**7. Have you been vaccinated against influenza during the fall of 2019 / winter 2020 ?**

- No
- Yes
- Do not know

**8. Have you been vaccinated against pneumococcal disease during the fall of 2019 / winter 2020 ?**

- No
- Yes
- Do not know

**9. How many people do you live with?**

- 0
- 1
- 2
- 3
- 4
- 5 or more

*These two questions appear only if the option "1" is selected in the question "9. How many people do you live with? "*

**Have any of your co-habitants been ill with respiratory symptoms in the last 14 days ?**

- No
- Yes
- Do not know

**Have any of your co-habitants been diagnosed with coronavirus infection?**

- No
- Yes
- Do not know

*These two questions appear only if the option "2" is selected in the question "9. How many people do you live with? "*

**How many of your co-habitants have been ill with respiratory symptoms in the last 14 days ?**

- 0
- 1

2

**How many of your co-habitants have been diagnosed with a coronavirus infection?**

- 0
- 1
- 2

*These two questions appear only if the option "3" is selected in the question "9. How many people do you live with? "*

**How many of your co-habitants have been ill with respiratory symptoms in the last 14 days ?**

- 0
- 1
- 2
- 3

**How many of your co-habitants have been diagnosed with a coronavirus infection?**

- 0
- 1
- 2
- 3

*These two questions appear only if the option "4" is selected in the question "9. How many people do you live with? "*

**How many of your co-habitants have been ill with respiratory symptoms in the last 14 days ?**

- 0
- 1
- 2
- 3
- 4

**How many of your co-habitants have been diagnosed with a coronavirus infection?**

- 0
- 1
- 2
- 3
- 4

*These two questions appear only if the option "5 or more" is selected in the question "9. How many people do you live with? "*

**How many of your co-habitants have been ill with respiratory symptoms in the last 14 days ?**

- 0
- 1
- 2
- 3
- 4
- 5 or more

**How many of your co-habitants have been diagnosed with a coronavirus infection?**

- 0
- 1
- 2
- 3

4

5 or more

**10. State how much you have been plagued by the following issues over the past 14 days :**

**I find it difficult to touch an object when I know it has been touched by strangers or specific people.**

Never

Seldom

Sometimes

Often

Almost Always

**Sometimes I have to wash or clean myself simply because I feel contaminated.**

Never

Seldom

Sometimes

Often

Almost Always

**I wash my hands more often and longer than necessary.**

Never

Seldom

Sometimes

Often

Almost Always

**11. How are you now? Below is a scale from 0 to 10, where 0 is the worst and 10 is the best. Please indicate on this scale your current wellbeing and status:**

0 - worst

1

2

3

4

5

6

7

8

9

10 - best

**12. Have you been bothered by any of the following in the last 14 days ?**

Not bothered

Sometimes

Often

Almost Always

Still scared or anxious

Nervousness, inner turmoil

Feeling hopeless with regard to the future

Depressed, melancholy

Very worried or uneasy

**13. What was your typical occupation (before the corona pandemic)?**

Pupil / student  
Trainee / Apprentice  
Military service  
Seeking Employment / Furloughed / Laid Off  
Rehabilitation / Disabled  
Public sector employee  
Private business employee  
Self-employed  
Other

**14. Which of the following industries do you typically work in?:**

Health/healthcare  
Retail/Shop  
Transportation  
Fire / Rescue / Police  
School / College / University  
None of these

**15. Has your occupational status changed as a result of the corona pandemic?**

No  
Yes, furloughed/laid off  
Yes, lost job  
Yes, received new job tasks/responsibilities

**16. Have you lost income as a result of the coronavirus?**

No  
Yes, some loss of income  
Yes, significant loss of income  
Do not know

**17. Are you pregnant now?**

No  
Yes  
Do not know

## **YOUR CHILD WHO IS IN NORFLU**

**18. Has the child become ill with respiratory symptoms, illness or fever within the last 14 days ?**

No  
Yes

*Question 18.1 .-. 18.15. appears only if the option "Yes" is selected in the question "18. Has the child become ill with respiratory symptoms, illness or fever within the last 14 days ? "*

**18.1. How many days has it been since the illness / symptoms began?**

0-1 day  
2-3 days  
4-5 days

6-7 days  
8-9 days  
10-14 days

**18.2. Check *how sick the child was*:**

Not very ill  
Quite ill, in bed for several days  
Very ill

**18.3. Check *how long the child was ill*:**

1-2 days  
3-5 days  
6 days or more  
Do not know

**18.4. Check *when your child felt the sickest*:**

1-2 days after symptom(s) onset  
3-5 days after symptom(s) onset  
6 days or more after symptom(s) onset  
Do not know

**18.5. Does the child still have a cough?**

No  
Yes

*Appears only if the option "Yes" is selected in the question "18.5. Does the child still have a cough? "*

**Does the child have a dry cough or does your child produce mucus?**

Dry Cough  
Cough with mucus

**18.6. Does the child still have a runny nose or sneezing?**

No  
Yes

**18.7. Does the child still have a stuffy nose/nasal congestion?**

No  
Yes

**18.8. Does the child still have a sore throat?**

No  
Yes

*Appears only if the option "Yes" is selected in the question "18.8. Does the child still have a sore throat? "*

**Is it painful for your child to swallow?**

No  
Yes

**18.9. Does your child still have tightness in the chest (heavy breathing)?**

No  
Yes

**10.18. Has your child had a headache today or in the past 3 days ?**

No  
Yes

**11.18. Has your child had a fever today or in the last 3 days ?**

No  
Yes

*Appears only if the option "Yes" is selected in the question "18.11. Has the child had a fever today or in the past 3 days ?"*

**Has the child felt very cold (trembling) or experienced severe sweating?**

No  
Yes

**12.18. Has the child today or during the past 3 days had stomach pain / nausea / diarrhea?**

No  
Yes

**18.13. Has your child had a decreased sense of smell or taste in the past 3 days ?**

No  
Yes

**18.14. Has your child had any muscle pain for the past 3 days ?**

No  
Yes

**18.15. Has your child experienced dizziness in the last 3 days ?**

No  
Yes

**19. Has the child been examined by / had a consultation with a doctor (eg telephone) during the last 14 days ?**

No  
Yes

*Appears only if the option "Yes" is selected in the question "19. If the child has been examined by / had a consultation with a doctor (f. Ex. Telephone) during the last 14 days ?"*

**Check if the child has received any of the following diagnoses, or no diagnosis:**

Suspected or confirmed coronavirus disease

Suspected or confirmed influenza

Pneumonia

Sore throat

Cold

Other infection

Injury

Other illness

No diagnosis

**20. Has the child been hospitalized in the last 14 days ?**

No  
Yes

**21. Has the child been tested for corona or influenza virus infection within the last 14 days ?**

No  
Yes  
Do not know

*Appears only if the option "Yes" is selected in the question "21. Has the child been tested for coronary or influenza virus infection within the last 14 days ? "*

**Did the test confirm that the child had a coronavirus infection?**

No  
Yes  
Do not know

**Did the test confirm that the child had an influenza virus infection?**

No  
Yes  
Do not know

**22. Has the child been quarantined / isolated over the past 14 days ?**

No  
Yes

*Appears only if the option "Yes" is selected in the question "22. Has the child been quarantined / isolated over the past 14 days ? "*

**Check why the child has been quarantined / isolated:**

Have been abroad  
Have symptoms of illness  
Confirmed coronavirus infection  
Has been in contact with people who are infected  
Another reason

**23. Check if the child has any of the following diseases:**

Asthma or other lung disease  
Cancer  
Heart disease  
Diabetes  
Other illness  
Has no illness

**24. Has the child been vaccinated against influenza during the fall of 2019 / winter 2020 ?**

No  
Yes  
Do not know

**25. Did the child receive a vaccine against pneumococcal disease (outside the child vaccination program) during the fall 2019 / winter 2020 ?**

No  
Yes  
Do not know

**Thank you for filling out and submitting the form!**