Resize font:

Survey

Please complete the survey below.

Thank you!

Study ID

Race

What is your race? Mark one or more boxes.

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Some other race

Ethnicity

Are you of Hispanic or Latino origin?

- [ ] Yes, of Hispanic or Latino origin
- [ ] No, not of Hispanic or Latino origin

Age

What is your age?

Age in years. For babies less than 1 year old, write 0 as the age

Sex

What is your biological sex assigned at birth?

- ○ Male
- ○ Female
- ○ Intersex
- ○ None of these describe me

reset

Education

How many years of education have you completed?

Years of education from 0 - 20+

Domicile

Zip or Postal Code:

5-digit zip code

Employment

Are you employed?

- ○ Employed in a permanent position
- ○ Employed in a temporary position
- ○ Not currently employed

reset

Insurance Status

What kind of health insurance do you have?

- ○ Private insurance
- ○ Public insurance
- ○ None

reset

Disability Status

Are you deaf or do you have serious difficulty hearing?

- ○ Yes
- ○ No

reset

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- ○ Yes
- ○ No

reset

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- ○ Yes
- ○ No

reset

Do you have serious difficulty walking or climbing stairs?

- ○ Yes
- ○ No

reset

Do you have difficulty dressing or bathing?

- ○ Yes
- ○ No

reset

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- ○ Yes
- ○ No

reset

Medical History

Vaping Use

- ○ Yes
- ○ No

reset

Nicotine Use

- ○ Yes
- ○ No

reset

Alcohol Use

- ○ Yes
- ○ No

reset

Asthma

- ○ Yes
- ○ No

reset

Cancer

- ○ Yes
- ○ No

reset

Cardiovascular disease

- ○ Yes
- ○ No

reset

Chronic kidney disease

- ○ Yes
- ○ No

reset

Chronic lung disease

- ○ Yes
- ○ No

reset

Diabetes

- ○ Yes
- ○ No

reset

Hypertension

- ○ Yes
- ○ No

reset

Immunosuppressive condition

- ○ Yes
- ○ No

reset

Serious mental illness

- ○ Yes
- ○ No

reset

Sickle cell disease

- ○ Yes
- ○ No

reset

Symptoms

Cough

- ○ Yes
- ○ No

reset

Fever

- ○ Yes
- ○ No

reset

Shortness of breath or difficulty breathing

- ○ Yes
- ○ No

reset

Headache

- ○ Yes
- ○ No

reset

Muscle ache

- ○ Yes
- ○ No

reset

New loss of taste or smell

- ○ Yes
- ○ No

reset

Chills

- ○ Yes
- ○ No

reset

Excessive fatigue

- ○ Yes
- ○ No

reset

Nausea/vomiting

- ○ Yes
- ○ No

reset

Diarrhea

- ○ Yes
- ○ No

reset

Abdominal pain

- ○ Yes
- ○ No

reset

Skin rash

- ○ Yes
- ○ No

reset

Conjunctivitis

- ○ Yes
- ○ No

reset

Health status

What is your height?

[ ] **feet**
[ ] **in**

What is your weight?

[ ]
Weight in pounds

Would you say that (your) health in general is excellent, very good, good, fair or poor?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

reset

Submit