

COVID-19 Data Dictionary: Common Investigation Protocol

Question	Choices	Field Note
Reporting jurisdiction	—	Health jurisdiction reporting
Case state/local ID	—	If available
Reporting health department	—	Name of institution reporting
CDC 2019-nCoV ID	—	If available
Hospital MRN	—	Hospital medical record number

Interviewer Information

Question	Choices	Field Note
Name of Interviewer: Last	—	Last name of abstractor
Name of Interviewer: First	—	First name of abstractor
Affiliation/Organization	—	—
Telephone	—	Telephone of abstractor
Email	—	Email of abstractor
Date of interview	—	[MM/DD/YYYY]
Date of medical chart abstraction	—	[MM/DD/YYYY]
Data sources used for this form	Case-patient interview Other interview, specify relationship to case Medical Chart Abstraction	Select one, if 'Other interview,' specify the relationship to the interviewee to the case
Case-patient's primary language	—	—
Was this form administered via a translator?	Yes No Unknown	Select one

Case-Patient Demographic Information

Question	Choices	Field Note
Q1. Patient age in years (Age Unit)	Years Months Days	Age in selected unit
Q2. Patient sex	Male Female Other Unknown	Select one
Q3. Patient ethnicity	Hispanic/Latinx Non-Hispanic/Latinx Unknown	Select one
Q4. Patient race	White Black Asian American Indian/ Alaska Native Native Hawaiian/Other Pacific Islander Unknown Other	Select one; if 'Other,' specify



Question	Choices	Field Note
Q5. County of residence	—	—
State of Residence	—	2 letter abbreviation
Q6. Country of Residence	United States Other, specify	Select one; if 'Other', specify
Q7. Occupation	—	—
Q8. Was this patient employed as a health care worker or first responder since Jan 1st, 2020?	Yes No Unknown	Select one
Q9. Was this patient a long-term care facility resident prior to initial diagnosis?	Yes No Unknown	Select one
Q10. Was the patient employed in a laboratory that processes SARS-CoV-2 samples?	Yes No Unknown	Select one
Q11. Has the patient visited, worked at, or resided in any of the following:	Prison Meat processing plant Church School: Preschool / K-12 / College Other congregate setting, describe None	Select one; if 'Other', specify
Q12. Did the patient come into contact with a person with known SARS-CoV-2 infection in the two weeks prior to their second illness episode?	Yes No Unknown	Select one

First Episode

Question	Choices	Field Note
Q13. Date of 1st positive PCR test:	—	[MM/DD/YYYY]
Q14. If symptomatic on 1st episode, date of symptom onset:	Provide date Asymptomatic Unknown	If symptomatic, provide date [MM/DD/YYYY]; if not, select one option
Q15. What were the symptoms on presentation:	—	Go to table

Symptoms

Symptom	Choices	Field Note
Fever $\geq 100.4F$ (38C)	Yes No Unknown	Select one
Subjective fever (felt feverish)	Yes No Unknown	Select one
Chills	Yes No Unknown	Select one
Rigors	Yes No Unknown	Select one
Muscle aches (myalgia)	Yes No Unknown	Select one
Runny nose (rhinorrhea)	Yes No Unknown	Select one
Sore throat	Yes No Unknown	Select one
New olfactory and taste disorder(s)	Yes No Unknown	Select one

Symptom	Choices	Field Note
Headache	Yes No Unknown	Select one
Fatigue	Yes No Unknown	Select one
Cough (new onset or worsening of chronic cough)	Yes No Unknown	Select one
Wheezing	Yes No Unknown	Select one
Shortness of breath (dyspnea)	Yes No Unknown	Select one
Difficulty breathing	Yes No Unknown	Select one
Chest Pain	Yes No Unknown	Select one
Nausea or vomiting	Yes No Unknown	Select one
Abdominal pain	Yes No Unknown	Select one
Diarrhea (≥ 3 loose/looser than normal stools/24hr period)	Yes No Unknown	Select one
Other, specify:	Yes No Unknown	Select one, if 'Yes,' specify

First Episode — Continued

Question	Choices	Field Note
Q16. What is the highest level of care received during this episode?	Self-care/Over-the-counter Outpatient/ Telemedicine Emergency department/ urgent care Hospitalized Intensive Care Unit Received mechanical ventilation	Select one
Q17. If hospitalized, what was the length of stay:	—	Report in days
Q18. If hospitalized, date of discharge:	—	[MM/DD/YYYY]
Q19. Did the patient receive treatment for SARS-CoV-2?	Yes No N/A	Select one
If yes, specify	—	Specify drug, dosage, and duration
Q20. Did the patient recover (defined as afebrile without antipyretics AND progressive improvement/ resolution of symptoms)?	Yes No N/A	Select one
If yes, date of recovery	—	[MM/DD/YYYY]
Q21. Comments about 1st course of illness:	—	Free response

Second Episode

Question	Choices	Field Note
Q22. Date of suspected SARS-CoV-2 reinfection positive PCR test:	—	[MM/DD/YYYY]
Q23. If symptomatic on 2nd episode, date of symptom onset:	Provide date Asymptomatic Unknown	If symptomatic, provide date [MM/DD/YYYY]; if not, select one option
Q24. What were the symptoms on presentation:	—	Go to table

Symptoms

Symptom	Choices	Field Note
Fever ≥ 100.4 F (38C)	Yes No Unknown	Select one
Subjective fever (felt feverish)	Yes No Unknown	Select one
Chills	Yes No Unknown	Select one
Rigors	Yes No Unknown	Select one
Muscle aches (myalgia)	Yes No Unknown	Select one
Runny nose (rhinorrhea)	Yes No Unknown	Select one
Sore throat	Yes No Unknown	Select one
New olfactory and taste disorder(s)	Yes No Unknown	Select one
Headache	Yes No Unknown	Select one
Fatigue	Yes No Unknown	Select one
Cough (new onset or worsening of chronic cough)	Yes No Unknown	Select one
Wheezing	Yes No Unknown	Select one
Shortness of breath (dyspnea)	Yes No Unknown	Select one
Difficulty breathing	Yes No Unknown	Select one
Chest Pain	Yes No Unknown	Select one
Nausea or vomiting	Yes No Unknown	Select one
Abdominal pain	Yes No Unknown	Select one
Diarrhea (≥ 3 loose/looser than normal stools/24hr period)	Yes No Unknown	Select one
Other, specify:	Yes No Unknown	Select one, if 'Yes,' specify

Second Episode — Continued

Question	Choices	Field Note
Q25. What is the highest level of care received during this episode?	Self-care/Over-the-counter Outpatient/Telemedicine Emergency department/urgent care Hospitalized Intensive Care Unit Received mechanical ventilation	Select one

Question	Choices	Field Note
Q26. If hospitalized, what was the length of stay:	—	Report in days
Q27. If hospitalized, date of discharge:	—	[MM/DD/YYYY]
Q28. Did the patient receive treatment for SARS-CoV-2?	Yes No N/A	Select one
If yes, specify:	—	Specify drug, dosage, and duration
Q29. Did the patient recover (defined as afebrile without antipyretics AND progressive improvement/ resolution of symptoms)?	Yes No N/A	Select one
If yes, date of recovery:	—	[MM/DD/YYYY]
Q30. If symptoms are ongoing, what is the date of last known symptoms for 2nd episode?	—	[MM/DD/YYYY]
Q31. If symptomatic, are the recurrent symptoms better explained by a non-COVID-19 etiology?	Yes No	Select one
If yes, what laboratory evidence supports an alternative etiology:	—	Alternative etiology and diagnostic test
Q32. Does the treating physician suspect that this is a case of SARS-CoV-2 reinfection?	Yes No Unknown	Select one
Q33. Comments about 2nd course of illness	—	Free response

Past Medical History

Question	Choices	Field Note
Q34. Does the patient have any pre-existing medical conditions	Yes No Unknown	Select one
Chronic lung disease	Yes No Unknown	Select one
Asthma/reactive airway disease	Yes No Unknown	Select one
Emphysema/COPD	Yes No Unknown	Select one
Other chronic lung disease	Yes No Unknown	Select one, if 'Yes,' specify
Active tuberculosis	Yes No Unknown	Select one
Diabetes Mellitus	Yes No Unknown	Select one
Other endocrine disorder	Yes No Unknown	Select one, if 'Yes,' specify
Cardiovascular disease	Yes No Unknown	—
Hypertension	Yes No Unknown	—
Coronary artery disease	Yes No Unknown	—
Heart failure/Congestive heart failure	Yes No Unknown	—

Question	Choices	Field Note
Cerebrovascular accident/Stroke	Yes No Unknown	—
Congenital heart disease	Yes No Unknown	—
Other	Yes No Unknown	Select one, if 'Yes,' specify
Renal disease	Yes No Unknown	—
Chronic kidney disease/ insufficiency	Yes No Unknown	—
End-stage renal disease	Yes No Unknown	—
Dialysis	Yes No Unknown	—
Hemodialysis	Yes No Unknown	—
Peritoneal dialysis	Yes No Unknown	—
Other	Yes No Unknown	Select one, if 'Yes,' specify
Liver disease	Yes No Unknown	—
Alcoholic hepatitis	Yes No Unknown	—
Chronic liver disease	Yes No Unknown	—
Cirrhosis/End stage liver disease	Yes No Unknown	—
Hepatitis B, chronic	Yes No Unknown	—
Hepatitis C, chronic	Yes No Unknown	—
Non-alcoholic fatty liver disease (NAFLD)/NASH	Yes No Unknown	—
Other	Yes No Unknown	Select one, if 'Yes,' specify
Immunocompromised Condition	Yes No Unknown	—
HIV infection	Yes No Unknown	—
AIDS or CD4 count <200	Yes No Unknown	—
Solid organ transplant	Yes No Unknown	—
Stem cell transplant (e.g., bone marrow transplant)	Yes No Unknown	—
Cancer: current/in treatment or diagnosed in last 12 months	Yes No Unknown	—
Other	Yes No Unknown	Select one, if 'Yes,' specify
Immunosuppressive therapy	Yes No Unknown	Select one, if 'Yes,' specify and list for what condition
Neurologic/neurodevelopmental disorder	Yes No Unknown	Select one, if 'Yes,' specify
Rheumatologic disorder	Yes No Unknown	Select one, if 'Yes,' specify
Psychiatric diagnosis	Yes No Unknown	Select one, if 'Yes,' specify
Blood disorder (e.g., sickle cell anemia)	Yes No Unknown	Select one, if 'Yes,' specify
Other chronic diseases	Yes No Unknown	Select one, if 'Yes,' specify

Laboratory Specimens and SARS-CoV-2 Testing

Record all SARS-CoV-2 diagnostic tests in the table provided in the case report form. Each 'Question' below corresponds to a column of the table.

Question	Choices	Field Note
Date of collection	—	[MM/DD/YYYY]
Specimen Type	—	—
Test Type	—	—
Result	Pos Neg	Select one; Pos = Positive; Neg = Negative
Lowest Ct Value if PCR	—	Record a numeric value if available or 'N/A' if not available
Copy of Report Available	Yes No	Select one
Specimen Available	Yes No Unknown	Select one