Participant Information

Please complete the survey below.

Thank you!

Participant Study ID	_____
Today's Date	_____
Participant Full Name	_____ (Please type your first and last name)
Date of Birth	_____ (Click on the calendar logo to select a date)
Height (in)	_____
Weight (lbs)	_____
BMI	_____
Did you experience any symptoms due to COVID-19?	◯ Yes ◯ No - I was asymptomatic
What day did these symptoms begin?	_____ (Give your closest approximation)
What was the date of your positive test? If you tested positive multiple times, please select the date of your earliest positive test.	_____
Are you still experiencing symptoms due to COVID-19?	Yes No
How long did it take for symptoms from this illness episode to subside?	◯ 3 days ◯ 5 days ◯ 7 days ◯ 10 days ◯ 2 weeks ◯ 3 weeks ◯ 4 weeks or more (Provide your closest approximation)

Which symptoms have you continued to experience? Please select all that apply	Feeling feverish Cough Chills or shivering Sweats Sore throat or itchy/scratchy throat Nausea or vomiting Runny or stuffy nose Muscle or body aches Increased trouble breathing Fatigue Diarrhea Rash Ear pain or ear discharge Loss of sense of taste Loss of sense of smell Headache Chest pain Joint pain Dry eyes and mouth Vertigo Lack of appetite Lowering of vision Fainting Nerve pain Other
Please describe what other symptom(s) you are currently experiencing due to COVID-19.	_____
Did you access any of the following types of care after your COVID-19 symptoms resolved?	☐ Drive-through testing only ☐ Saw primary care doctor / nurse practitioner / physician assistant ☐ Urgent Care ☐ Emergency room ☐ Admitted to hospital ☐ Admitted to ICU ☐ None of the above ☐ Do not know ☐ Prefer not to say

Questionnaire

Please complete the survey below.

Thank you!

In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your illness onset on [symptom_onset], compared to your ability to perform these activities today.

In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your diagnosis on [test_date], compared to your ability to perform these activities today.

How do you rate your health before you had COVID-19?

Worst imaginable health — Best imaginable health

(Place a mark on the scale above)

How do you rate your health today?

Worst imaginable health — Best imaginable health

(Place a mark on the scale above)

Climbing stairs and transferring

This includes any of the following: getting into/out of bed, standing up/sitting down in a chair, getting into/out of a car, getting on/off a toilet, stepping onto a curb.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need climbing stairs/transferring?	○	○	○	○
TODAY, how much help do you need climbing stairs/transferring?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Personal grooming and dressing

This includes any of the following: brushing/flossing teeth, denture care, skin care, shaving, putting on socks and shoes, taking off underwear, putting on pants, putting on a jacket.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task

BEFORE you were diagnosed with COVID-19, how much help did you need with personal grooming and dressing?	○	○	○	○
TODAY, how much help do you need with personal grooming and dressing?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Using the toilet and bathing

This includes any of the following: wiping your body with wipes, taking a shower or bath, scrubbing and rinsing your body, wiping after you use the toilet.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need using the restroom and bathing?	○	○	○	○
TODAY, how much help do you need using the restroom and bathing?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Doing household chores

This includes any of the following: food preparation, cooking, folding laundry, vacuuming the floor, making the bed, feeding pets, wiping a table, loading the dishwasher, tidying up a room.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task

BEFORE you were diagnosed with COVID-19, how much help did you need doing household chores?	○	○	○	○
TODAY, how much help do you need doing household chores?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Managing personal affairs

This includes any of the following: using the phone or computer, paying bills, scheduling a doctor appointment, managing medications, refilling a prescription, making a shopping list

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need managing your personal affairs?	○	○	○	○
TODAY, how much help do you need managing your personal affairs?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Do you experience shortness of breath or fatigue when performing any activities in the following categories? Please select all that apply.

- ☐ Climbing stairs or transferring
- ☐ Personal grooming and dressing
- ☐ Using the toilet and bathing
- ☐ Doing household chores
- ☐ Managing personal affairs

When you are climbing stairs or transferring, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time

When you are dressing or performing personal grooming, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time

When you are using the toilet or bathing, how often do you feel shortness of breath/fatigue?	☐ 0-25% of the time ☐ 25-50% of the time ☐ 50-75% of the time ☐ 75-100% of the time
When you are doing household chores, how often do you feel shortness of breath/fatigue?	☐ 0-25% of the time ☐ 25-50% of the time ☐ 50-75% of the time ☐ 75-100% of the time
When you are managing your personal affairs, how often do you feel shortness of breath/fatigue?	☐ 0-25% of the time ☐ 25-50% of the time ☐ 50-75% of the time ☐ 75-100% of the time

Lingering Symptoms

Please complete the survey below.

Thank you!

Today's Date

_____

Participant Full Name

_____
(Please type your first and last name)

Are you still experiencing symptoms due to COVID-19?

- ◯ Yes
- ◯ No

Which symptoms have you continued to experience? Please select all that apply

- ☐ Feeling feverish
- ☐ Cough
- ☐ Chills or shivering
- ☐ Sweats
- ☐ Sore throat or itchy/scratchy throat
- ☐ Nausea or vomiting
- ☐ Runny or stuffy nose
- ☐ Muscle or body aches
- ☐ Increased trouble breathing
- ☐ Fatigue
- ☐ Diarrhea
- ☐ Rash
- ☐ Ear pain or ear discharge
- ☐ Loss of sense of taste
- ☐ Loss of sense of smell
- ☐ Headache
- ☐ Chest pain
- ☐ Joint pain
- ☐ Dry eyes and mouth
- ☐ Vertigo
- ☐ Lack of appetite
- ☐ Lowering of vision
- ☐ Fainting
- ☐ Nerve pain
- ☐ Other

Please describe what other symptom(s) you are currently experiencing due to COVID-19.

_____

Have you accessed any of the following types of care after your previous HAARVI appointment, related to lingering COVID-19 symptoms?

- ☐ Drive-through testing only
- ☐ Saw primary care doctor / nurse practitioner / physician assistant
- ☐ Urgent Care
- ☐ Emergency room
- ☐ Admitted to hospital
- ☐ Admitted to ICU
- ☐ None of the above
- ☐ Do not know
- ☐ Prefer not to say

In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your illness onset on [symptom_onset], compared to your ability to perform these activities today.

In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your diagnosis on [test_date], compared to your ability to perform these activities today.

How do you rate your health before you had COVID-19?

Worst imaginable health — Best imaginable health

(Place a mark on the scale above)

How do you rate your health today?

Worst imaginable health — Best imaginable health

(Place a mark on the scale above)

Climbing stairs and transferring

This includes any of the following: getting into/out of bed, standing up/sitting down in a chair, getting into/out of a car, getting on/off a toilet, stepping onto a curb.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need climbing stairs/transferring?	○	○	○	○
TODAY, how much help do you need climbing stairs/transferring?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Personal grooming and dressing

This includes any of the following: brushing/flossing teeth, denture care, skin care, shaving, putting on socks and shoes, taking off underwear, putting on pants, putting on a jacket.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need with personal grooming and dressing?	○	○	○	○

TODAY, how much help do you need with personal grooming and dressing?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.
)

Using the toilet and bathing

This includes any of the following: wiping your body with wipes, taking a shower or bath, scrubbing and rinsing your body, wiping after you use the toilet.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need using the restroom and bathing?	○	○	○	○
TODAY, how much help do you need using the restroom and bathing?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.
)

Doing household chores

This includes any of the following: food preparation, cooking, folding laundry, vacuuming the floor, making the bed, feeding pets, wiping a table, loading the dishwasher, tidying up a room.

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need doing household chores?	○	○	○	○
TODAY, how much help do you need doing household chores?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Managing personal affairs

This includes any of the following: using the phone or computer, paying bills, scheduling a doctor appointment, managing medications, refilling a prescription, making a shopping list

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need managing your personal affairs?	○	○	○	○
TODAY, how much help do you need managing your personal affairs?	○	○	○	○

Please state which activities, if any, have been impacted and describe how they have been impacted.

_____

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Do you experience shortness of breath or fatigue when performing any activities in the following categories? Please select all that apply.

- ☐ Climbing stairs or transferring
- ☐ Personal grooming and dressing
- ☐ Using the toilet and bathing
- ☐ Doing household chores
- ☐ Managing personal affairs

When you are climbing stairs or transferring, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time

When you are dressing or performing personal grooming, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time

When you are using the toilet or bathing, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time

When you are doing household chores, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time

When you are managing your personal affairs, how often do you feel shortness of breath/fatigue?

- ☐ 0-25% of the time
- ☐ 25-50% of the time
- ☐ 50-75% of the time
- ☐ 75-100% of the time