PARTICIPANT IDENTIFICATION# : [__][__][__][__][__]-[__][__][__][__]

SURVEY TIMEPOINT (to be completed by the team before sending or administering the survey):
> 3 -6m [_] > 6- 9m [_] > 9 -12m [_] > 12 - 18m [__] > 18-24m[__] >24- 36m [_] > 36m[_]

1. About you and your COVID-19 illness (if you're completing this survey on behalf of a child or adult that you care for, all the questions relate to their health and wellbeing)

Date you did this survey (DD/MM/YYYY): [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
What is your date of birth (DD/MM/YYYY): [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Have you been vaccinated against Covid-19? ☐ Yes ☐ No ☐ Not sure
If yes, how many times have you had the Covid-19 vaccine? [_Number_]
Estimated date of the last vaccine dose received: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Which type of Covid-19 vaccine did you receive: ☐AstraZeneca ☐Pfizer-BioNTech ☐Imperial ☐ Janssens ☐Moderna's ☐Sinopharm ☐Sputnik V ☐Other (name): _________ ☐Not sure

Have you been vaccinated against influenza within last 6 months? ☐ Yes ☐ No ☐ Not sure
Have you visited a healthcare center due to COVID-19 since the last follow up survey? ☐ Yes ☐ No

Have you been admitted to hospital due to COVID-19? ☐ Yes ☐ No

- Have you been re-admitted to hospital or a health facility after your first acute Covid-19 illness? ☐ Yes ☐ No

If yes, how many times: [_Number_] If yes, specify reason: _______________
Name of hospital/s:____

If ever admitted to hospital/health facility for Covid-19, were you admitted to intensive care (ICU/ITU)? ☐ Yes ☐ No ☐ Not sure

2. About your health now

Do you feel fully recovered from COVID-19?
☐ Strongly disagree ☐ Disagree ☐ Neither disagree nor agree ☐ Agree ☐ Strongly Agree

Have you felt feverish recently? ☐ Yes ☐ No ☐ Not sure

If yes roughly when did you last feel feverish?
☐ within last 7 days
☐ between 1 to 2 weeks ago
☐ between 2 to 4 weeks ago
☐ between 1 to 2 months ago
☐ between 2 to 3 months ago

If yes, what was the cause of your most recent feverish illness?
☐ COVID -19 ☐ Other respiratory infection (cough/cold/sore throat)
☐ Stomach infection (diarrhoea/vomiting) ☐ Urinary infection
☐ TB ☐ Other: specify: ____________________
☐ Unknown ☐ Prefer not to say

3. Since having COVID-19, have you been diagnosed with any of these?

Heart attack ☐ Yes ☐ No
Stroke or mini stroke/TIA ☐ Yes ☐ No
Kidney problems ☐ Yes ☐ No
Deep vein thrombosis (DVT, "Clot in leg") ☐ Yes ☐ No
Pulmonary embolism (PE, "Clot in lung") ☐ Yes ☐ No
Other condition (please specify)?__________________

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PARTICIPANT IDENTIFICATION# : [__][__][__][__][__]-[__][__][__][__]

Within the last seven days have you had any of these symptoms? (that you did not experience before onset of your Covid-19 illness)

Symptom	Response
Headache	☐ Yes ☐ No
Persistent cough	☐ Yes ☐ No
If yes	☐ dry cough ☐ with phlegm
Loss of smell	☐ Yes ☐ No
Loss of taste	☐ Yes ☐ No
Shortness of breath/ breathlessness	☐ Yes ☐ No
Pain on breathing	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No
Palpitations (heart racing)	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No
Loss of appetite	☐ Yes ☐ No
Stomach /abdominal pain	☐ Yes ☐ No
Feeling sick/vomiting	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Diarrhoea	☐ Yes ☐ No
Problems passing urine	☐ Yes ☐ No
Erectile dysfunction	☐ Yes ☐ No ☐ N/A
Changes in menstruation	☐ Yes ☐ No ☐ N/A
Swollen ankle(s)	☐ Yes ☐ No
Problems with balance	☐ Yes ☐ No
Weakness in arms or legs / muscle weakness	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No
Persistent muscle pain	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No
Can’t fully move or control movement	☐ Yes ☐ No
Cant feel one side of the body or face	☐ Yes ☐ No
Tingling feeling/“pins and needles“	☐ Yes ☐ No
Dizziness/light headedness	☐ Yes ☐ No
Fainting/ blackouts	☐ Yes ☐ No
Seizures/fits	☐ Yes ☐ No
Tremor/shakiness	☐ Yes ☐ No
Confusion/lack of concentration	☐ Yes ☐ No
Problems swallowing or chewing	☐ Yes ☐ No
Problems seeing	☐ Yes ☐ No
Ringing in ears	☐ Yes ☐ No
Problems speaking or communicating	☐ Yes ☐ No
Problems sleeping	☐ Yes ☐ No
Lumps or rashes (purple/pink) on toes	☐ Yes ☐ No
Skin rash	☐ Yes ☐ No
If yes, please tick all body areas that apply:	☐ Face ☐ Trunk(stomach or back) ☐ Arms ☐ Legs ☐ Buttocks ☐ Toes ☐ Fingers
Bleeding	☐ Yes ☐ No
If yes, specify bleeding site: ______	
Any other NEW symptoms?	☐ Yes ☐ No
If yes, specify: ______	

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5. About your health

Under each heading, please tick the ONE box that best describes your health TODAY

MOBILITY

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES

(e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usually activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

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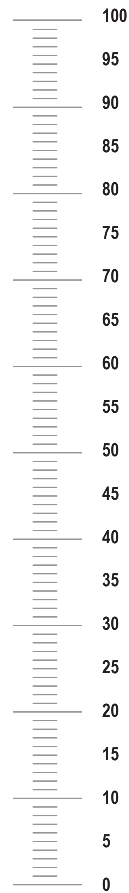
- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below

YOUR HEALTH TODAY = [ ]

THE BEST HEALTH YOU CAN IMAGINE



THE WORST HEALTH YOU CAN IMAGINE

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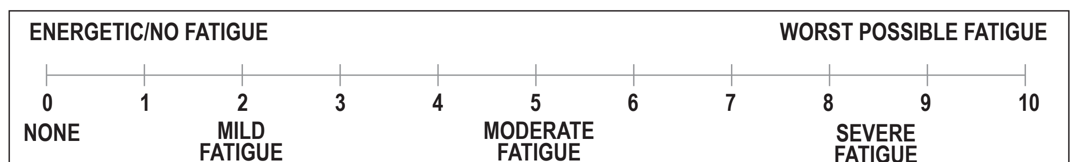
6. Breathlessness and tiredness

Please tick ONE box that best describes how breathless you feel Today	Within the last 24 hours (tick one box)
Not troubled by breathlessness except on strenuous exercise	
Short of breath when hurrying or when walking up a slight hill	
Walks slower than most people of my age because of breathlessness, or have to stop for breath when walking at own pace	
Stops for breath after walking 100 yards/ 90-100 meters, or after a few minutes on level ground	
Too breathless to leave the house, or breathless when dressing/undressing	

Please rate the intensity of your fatigue on average over the last 24 hours, on a scale from 0 – 10.

Where:
0 = No fatigue and
10 = fatigue as bad as you can imagine



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7. The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.	
(mark the correct answer with a tick in the box)	**Today**
Do you have difficulty seeing even if wearing glasses?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all
Do you have difficulty hearing, even if using a hearing aid?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all
Do you have difficulty walking or climbing steps?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all
Do you have difficulty remembering or concentrating?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all
Do you have difficulty (with self-care such as) washing all over or dressing?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all
Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all

8. Have you made lifestyle changes since your COVID-19 infection? (mark the correct answer with a tick in the box)

	I do this more often	I do this less often	No difference	I did not do this before Covid-19
Smoking				
Drinking alcohol				
Eating healthy food				
Physical activity (including walking & cycling)				

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9. A few questions about your occupation/working status

What is your main occupation/working status today?

☐ Same as before my Covid-19 illness ☐ Different from before my Covid-19 illness
☐ Prefer not to say

If different, please describe your occupation/working status today (tick all that apply to you)?

☐ Working full-time ☐ Working part-time ☐ Not working due to COVID-19 restrictions
☐ Sick leave ☐ Full time carer (children or others) ☐ Unemployed
☐ Unable to work due to chronic illness ☐ Student ☐ Retired
☐ Early retirement due to illness ☐ Earning more ☐ Earning less ☐ Prefer not to say

If different, why did you occupation/working status change?

☐ Poor health ☐ New caring responsibility ☐ Made redundant
☐ Working hours reduced by employer ☐ Sick leave ☐ Other (specify): ______________
☐ Prefer not to say

Have you been on sick leave from work or college/university due to your Covid-19 illness?

☐ Yes ☐ No ☐ Prefer not to say

If yes, for how long have you been off sick in total: [_Number_] indicate unit ☐ days ☐ weeks

10. A few questions about yourself

Sex at Birth: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Ethnicity (tick all that apply): ☐ White ☐ Arab ☐ Black ☐ East Asian ☐ South Asian
☐ West Asian ☐ Latin American
☐ Other (specify):________________________ ☐ Prefer not to say

What is your estimated height: _____. _____ **(metres/feet/inches – circle unit used)** ☐ Not sure

What is your current estimated weight: _____. _____ (kg/lbs – circle unit used) ☐ Not sure

How many other members regularly live in your household, including yourself: [_Number_]

What is your highest completed educational level:

☐ Primary education(3 to 7 years of school) ☐ Secondary education(8 yo 10 years of school)
☐ Upper Secondary education/High School (11 to 13 years of school) ☐ Vocational / practical school
☐ Higher College/University ☐ Bachelor degree ☐ Masters degree ☐ PhD
☐ Other (specify): ______________ ☐ Not completed formal education or training ☐ Prefer not to say

Number of years in formal education: [_Number_]

*Including primary school e.g. from 5-7 years of age, and higher education

11. Please let us know if you feel COVID-19 has affected your health or wellbeing in a way not described above?

____

____

12. End of survey

Thank you for your time!

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