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

COVID-19 Health and Wellbeing Follow Up Survey

SURVEY TIMEPOINT (to be completed by the team before sending or administering the survey):

[__] 1 – 3 months [__] > 3 -6m [__] > 6- 9m [__] > 9 -12m [__] > 12 - 18m

1a. 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 the survey (DD/MM/YYYY): [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

What is your date of birth (DD/MM/YYYY): [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

Roughly what date did you first experience symptoms of COVID-19?

[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

What symptoms did you experience in the first 14 days of your COVID-19 illness? (tick all that you experienced when you first became unwell with COVID-19)

☐Fever ≥ 38oC ☐ Cough ☐Shortness of breath ☐ Fatigue ☐ Pain on breathing ☐Chest pain

☐Loss or disturbed smell ☐Loss or disturbed taste ☐Runny nose ☐ Headache ☐Muscle pain

☐Abdominal pain ☐Vomiting ☐Diarrheoa ☐Confusion ☐Brain fog ☐No symptoms

☐Other:_____

Did you have a COVID-19 test taken when you first became unwell (within the first 7 to 10 days)?

☐ Yes ☐No ☐Not sure

If yes, was the test result: ☐Positive ☐ Negative ☐Inconclusive ☐Not sure

Roughly what date did you have the test: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

Was this test a (tick all that apply): ☐ Throat test ☐ Nose swab ☐ Blood test ☐Not sure

Was this test a ☐PCR test ☐ Antigen test ☐ Other test (specify): _____ ☐ Not sure

Have you had a COVID-19 positive test at any other time? ☐ Yes ☐No ☐Not sure

If yes, roughly what date was the test taken: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

Was this test a (tick all that apply): ☐Throat test ☐ Nose swab ☐Blood test ☐ Not sure

Was this test a: ☐PCR test ☐Antigen test ☐Antibody test

☐ Other test (specify): _____ ☐ Not sure

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 Covid19 vaccine dose received: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

Which type of Covid-19 vaccine did you receive: ☐AstraZeneca ☐Pfizer-BioNTech ☐Imperial

☐Janssens ☐ Moderna's ☐Sinopharm ☐ Sputnik V ☐Novavax ☐Other (name): _____

Have you been vaccinated against influenza within last 6 months? ☐ Yes ☐ No ☐ Not sure

Did you visit a doctor due to your COVID-19 illness? ☐ Yes ☐ No ☐ Not sure

If yes, how many times? [_Number_]

Were you admitted to hospital due to COVID-19 or diagnosed with COVID-19 during a hospital admission? ☐ Yes ☐ No ☐ Not sure

If yes please complete the questions below, if no skip to section 1b**:**

- Roughly at what date were you first admitted to hospital? [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
- Roughly at what date were you first discharged from hospital? [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

During the hospital admission did you receive treatment with any of the below:

Oxygen (e.g. via a mask or your nose to help you breathe) ☐ Yes ☐ No ☐ Not sure

Invasive ventilation (via a machine that breaths for you) ☐ Yes ☐ No ☐ Not sure

Where you admitted to an intensive care (ICU/ITU) ward ☐ Yes ☐ No ☐ Not sure

Have you been re-admitted to hospital or health facility after your first acute Covid-19 illness?

☐ Yes ☐ No ☐ Not sure

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

1b: Covid-19 treatments:

Have you taken medical treatments for Covid-19 during the acute phase (within the first month of onset of your Covid-19 illness): ☐ Yes ☐ No

If yes, please complete the questions below, if no skip to section 2.

Antiviral drugs: ☐ Yes ☐ No ☐ Not sure

If yes, please specify all taken: ☐ Lopinavir/Ritonavir ☐ Darunavir ☐ Remdesivir ☐ Favipiravir ☐ Acyclovir/Ganciclovir ☐ Oseltamivir ☐ Other (specify):_____ ☐ Not sure

Steroids: ☐ Yes ☐ No ☐ Not sure

If yes, please specify all: ☐ Dexamethasone ☐ Hydrocortisone ☐ Prednisone ☐ Methylprednisolone ☐ Other (specify):_____ ☐ Not sure

Antibiotics: ☐ Yes ☐ No ☐ Not sure, If yes, please specify name of all:

_____ _____ ☐ Not sure

Other medicines taken for your Covid-19 illness: ☐ Yes ☐ No ☐ Unknown

If yes, please specify name of all: _____

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 <u>most</u> 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

Deep vein thrombosis (DVT, “Clot in leg”) ☐ Yes ☐ No

Stroke or mini stroke/TIA ☐ Yes ☐ No

Pulmonary embolism (PE, “Clot in lung”) ☐ Yes ☐ No

Kidney problems ☐ Yes ☐ No

Other condition (please specify)?_____

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

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

5. About your health

Under each heading, please tick the ONE box that describes **your health BEFORE your COVID19 illness**

GETTING ABOUT

I had no problems in walking about ☐
I had slight problems in walking about ☐
I had moderate problems in walking about ☐
I had severe problems in walking about ☐
I was unable to walk about ☐

LOOKING AFTER YOURSELF

I had no problems washing or dressing myself ☐
I had slight problems washing or dressing myself ☐
I had moderate problems washing or dressing myself ☐
I had severe problems washing or dressing myself ☐
I was unable to wash or dress myself ☐

USUAL ACTIVITIES

(e.g. work, study, housework, family or leisure activities)
I had no problems doing my usual activities ☐
I had slight problems doing my usual activities ☐
I had moderate problems doing my usual activities ☐
I had severe problems doing my usually activities ☐
I was unable to do my usual activities ☐

PAIN / DISCOMFORT

I had no pain or discomfort ☐
I had slight pain or discomfort ☐
I had moderate pain or discomfort ☐
I had severe pain or discomfort ☐
I had extreme pain or discomfort ☐

ANXIETY/DEPRESSION

I was not anxious or depressed ☐
I was slightly anxious or depressed ☐
I was moderately anxious or depressed ☐
I was severely anxious or depressed ☐
I was extremely anxious or depressed ☐

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

GETTING ABOUT

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 ☐

LOOKING AFTER YOURSELF

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 ☐

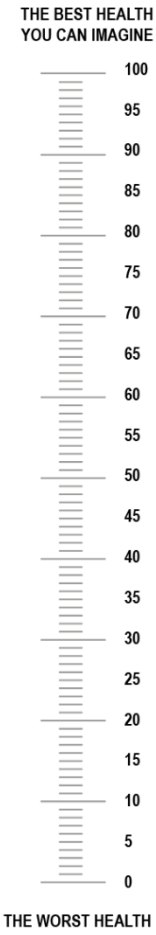
We would like to know how good or bad your health is TODAY.

- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.

scale in the box below

- 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 = [ ]

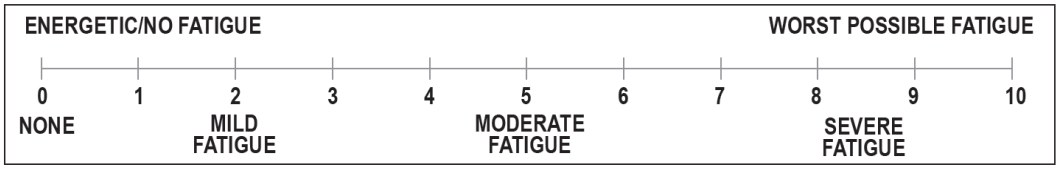


6. Breathlessness and tiredness

Please tick ONE box that best describes how breathless you feel Today and ONE box that describes how BREATHLESS you felt before your Covid illness	Within the last 24 hours (tick one box)	Before your Covid19 illness (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



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**	**Before your Covid19 illness**
Do you have difficulty seeing even if wearing glasses?	☐ No - no difficulty ☐ Yes – some difficulty ☐ Yes – a lot of difficulty ☐ Cannot do at all	☐ 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	☐ 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	☐ 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	☐ 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	☐ 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	☐ 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 and other activities)				

9. A few questions about your occupation/working status

Before you got COVID-19 what was your occupation/working status (paid or unpaid)?

☐ Working Full-time ☐ Working Part-time ☐ Full time carer (children or other) ☐ Unemployed
☐ Unable to work due to chronic illness ☐ Student ☐ Retired ☐ Medically retired ☐ Prefer not to say

What is your main occupation/working status today?

☐ Same as before ☐ Different from before ☐ 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 due to your Covid-19 illness*? ☐ Yes ☐ No ☐ Prefer not to say

* sick leave from school/university or work and full or part time sick leave

If yes, for how long ? [_Number_] indicate unit: ☐ days ☐ weeks

10. A few questions about yourself

Sex at Birth: ☐ Male ☐ Female ☐ Prefer not to say

If female, re you pregnant?: ☐ Yes ☐ No ☐ Not applicable

If yes: Gestational weeks assessment [__] weeks

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

Did you have a diagnosed chronic condition before your COVID-19 illness? ☐ Yes ☐ No

If yes, please specify all that are ongoing conditions:

☐ Chronic Heart disease ☐ High blood pressure ☐ Asthma ☐ Chronic lung disease (not asthma)
☐ Diabetes (if yes, ☐ type 1 ☐ Type 2 ☐ Gestational) ☐ Kidney disease ☐ Liver disease ☐ Asplenia
☐ Cancer ☐ Blood disorder ☐ Rheumatological disorder ☐ Neurological condition ☐ Dementia ☐ HIV
☐ Tuberculosis (TB) ☐ Depression ☐ Anxiety ☐ Other (please specify):_____

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

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

What was your estimated weight before your Covid19 illness? _____(kg/lbs – circle unit used)

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!