**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

**Date you did the survey (DD/MM/YYYY):** [D][M][M]/[M]/[M]/[2][0]/[2]/[Y]

**What is your date of birth (DD/MM/YYYY):** [D][D]/[M]/[M]/[M]/[2]/[0]/[2]/[Y]

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

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
- [ ] Diarrhoea
- [ ] 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]/[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): ______________

**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]/[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): ______________

**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]/[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]/[M]/[Y]
- Roughly at what date were you first discharged from hospital? [D]/[M]/[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 breathes 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

<table>
<thead>
<tr>
<th>Have you felt feverish recently?</th>
<th>□ Yes □ No □ Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes roughly when did you last feel feverish?</td>
<td>□ within last 7 days □ between 2 to 4 weeks ago □ between 2 to 3 months ago</td>
</tr>
</tbody>
</table>

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?

<p>| 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)? | |</p>
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss of smell</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss of taste</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shortness of breath/breathlessness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pain on breathing</td>
<td></td>
<td></td>
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<tr>
<td>Chest pains</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Palpitations (heart racing)</td>
<td></td>
<td></td>
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<tr>
<td>Weight loss</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss of appetite</td>
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<td></td>
<td></td>
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<tr>
<td>Stomach /abdominal pain</td>
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<tr>
<td>Feeling sick/vomiting</td>
<td></td>
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<tr>
<td>Constipation</td>
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<tr>
<td>Diarrhoea</td>
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<td></td>
<td></td>
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<tr>
<td>Problems passing urine</td>
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<td></td>
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<tr>
<td>Erectile dysfunction</td>
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<td></td>
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<tr>
<td>Changes in menstruation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Swollen ankle(s)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Problems with balance</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or legs / muscle weakness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Persistent muscle pain</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Joint pain or swelling</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Can’t fully move or control movement</td>
<td></td>
<td></td>
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<tr>
<td>Cant feel one side of the body or face</td>
<td></td>
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<tr>
<td>Tingling feeling/“pins and needles“</td>
<td></td>
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<tr>
<td>Dizziness/light headedness</td>
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<tr>
<td>Fainting/ black headedness</td>
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<tr>
<td>Seizures/fits</td>
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<tr>
<td>Tremor/shakiness</td>
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<tr>
<td>Confusion/lack of concentration</td>
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<tr>
<td>Problems swallowing or chewing</td>
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<tr>
<td>Problems seeing</td>
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<td></td>
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<tr>
<td>Problems speaking or communicating</td>
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<tr>
<td>Ringing in ears</td>
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<td></td>
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<tr>
<td>Problems sleeping</td>
<td></td>
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<tr>
<td>Lumps or rashes (purple/pink) on toes</td>
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<tr>
<td>Skin rash</td>
<td></td>
<td></td>
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<tr>
<td>Changes in menstruation</td>
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<td></td>
<td></td>
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<td>Swollen ankle(s)</td>
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<tr>
<td>Problems with balance</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or legs / muscle weakness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

If yes, please tick all body areas that apply:
- Face
- Trunk (stomach or back)
- Arms
- Legs
- Buttocks
- Toes
- Fingers

Bleeding
If yes, specify bleeding site:

Any other NEW symptoms?
If yes, specify:
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 usual 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 usual 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.

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

<table>
<thead>
<tr>
<th>Breathlessness</th>
<th>Within the last 24 hours (tick one box)</th>
<th>Before your Covid19 illness (tick one box)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not troubled by breathlessness except on strenuous exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short of breath when hurrying or when walking up a slight hill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walks slower than most people of my age because of breathlessness, or have to stop for breath when walking at own pace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stops for breath after walking 100 yards/90-100 meters, or after a few minutes on level ground</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too breathless to leave the house, or breathless when dressing/undressing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ENERGETIC/NO FATIGUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

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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)

<table>
<thead>
<tr>
<th></th>
<th>Today</th>
<th>Before your Covid19 Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have difficulty seeing even if wearing glasses?</td>
<td>No - no difficulty</td>
<td>No - no difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – some difficulty</td>
<td>Yes – some difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – a lot of difficulty</td>
<td>Yes – a lot of difficulty</td>
</tr>
<tr>
<td></td>
<td>Cannot do at all</td>
<td>Cannot do at all</td>
</tr>
<tr>
<td>Do you have difficulty hearing, even if using a hearing aid?</td>
<td>No - no difficulty</td>
<td>No - no difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – some difficulty</td>
<td>Yes – some difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – a lot of difficulty</td>
<td>Yes – a lot of difficulty</td>
</tr>
<tr>
<td></td>
<td>Cannot do at all</td>
<td>Cannot do at all</td>
</tr>
<tr>
<td>Do you have difficulty walking or climbing steps?</td>
<td>No - no difficulty</td>
<td>No - no difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – some difficulty</td>
<td>Yes – some difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – a lot of difficulty</td>
<td>Yes – a lot of difficulty</td>
</tr>
<tr>
<td></td>
<td>Cannot do at all</td>
<td>Cannot do at all</td>
</tr>
<tr>
<td>Do you have difficulty remembering or concentrating?</td>
<td>No - no difficulty</td>
<td>No - no difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – some difficulty</td>
<td>Yes – some difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – a lot of difficulty</td>
<td>Yes – a lot of difficulty</td>
</tr>
<tr>
<td></td>
<td>Cannot do at all</td>
<td>Cannot do at all</td>
</tr>
<tr>
<td>Do you have difficulty (with self-care such as) washing all over or dressing?</td>
<td>No - no difficulty</td>
<td>No - no difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – some difficulty</td>
<td>Yes – some difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – a lot of difficulty</td>
<td>Yes – a lot of difficulty</td>
</tr>
<tr>
<td></td>
<td>Cannot do at all</td>
<td>Cannot do at all</td>
</tr>
<tr>
<td>Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?</td>
<td>No - no difficulty</td>
<td>No - no difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – some difficulty</td>
<td>Yes – some difficulty</td>
</tr>
<tr>
<td></td>
<td>Yes – a lot of difficulty</td>
<td>Yes – a lot of difficulty</td>
</tr>
<tr>
<td></td>
<td>Cannot do at all</td>
<td>Cannot do at all</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>I do this more often</th>
<th>I do this less often</th>
<th>No difference</th>
<th>I did not do this before Covid-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking alcohol</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Eating healthy food</td>
<td></td>
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<tr>
<td>Physical activity</td>
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<tr>
<td>(including walking &amp; cycling and other activities)</td>
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</tbody>
</table>
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):

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, are 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):

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):

Number of years in formal education*: [Number]

*Including primary school e.g. from 5-7 years of age, and higher education
PARTICIPANT IDENTIFICATION# : [_______]__

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!