



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 the 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 influenza within last 6 months? Yes No Not sure

Have you had a pneumococcal vaccination within the last 5 years? Yes No Not sure

Roughly what day did you first experience symptoms of COVID-19? [D][D]/[M][M]/[2][0][Y][Y]

Were you admitted to hospital due to COVID-19? Yes No

• 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]

• Have you been re-admitted to hospital or health facility after your 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 Slightly disagree Slightly 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 2 to 4 weeks ago between 2 to 3 months ago between 1 to 2 weeks ago between 1 to 2 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)? _____

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

5. About your health

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

MOBILITY

- 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

SELF-CARE

- 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

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
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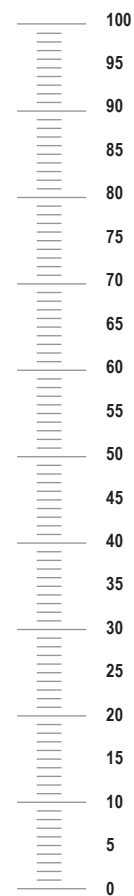
PAIN / DISCOMFORT

- 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

 THE BEST HEALTH
YOU CAN IMAGINE

 YOUR HEALTH TODAY =

 THE WORST HEALTH
YOU CAN IMAGINE

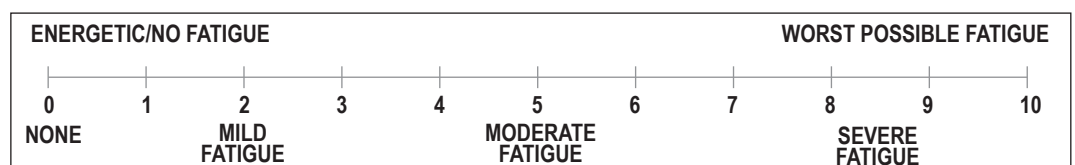
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6. Breathlessness and tiredness

Please tick ONE box that best describes how breathless you feel Today 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?	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all
Do you have difficulty hearing, even if using a hearing aid?	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all
Do you have difficulty walking or climbing steps?	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all
Do you have difficulty remembering or concentrating?	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all
Do you have difficulty (with self-care such as) washing all over or dressing?	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all
Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> Cannot do at all	<input type="checkbox"/> No - no difficulty <input type="checkbox"/> Yes – some difficulty <input type="checkbox"/> Yes – a lot of difficulty <input type="checkbox"/> 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)				

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

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

What was your estimated weight before your Covid19 illness? _____ . _____ (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: _____

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!