ISARIC

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

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 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 ☐ Not sure

Roughly what day did you first experience symptoms? [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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

- 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 <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?

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	Double vision ☐ Yes ☐ No
Constipation ☐ Yes ☐ No	Problems speaking or communicating ☐ Yes ☐ No
Diarrhoea ☐ Yes ☐ No	Problems sleeping ☐ Yes ☐ No
Problems passing urine ☐ Yes ☐ No	Lumps or rashes (purple/pink) on toes ☐ Yes ☐ No
Erectile dysfunction ☐ Yes ☐ No ☐ N/A	Skin rash ☐ Yes ☐ No
Changes in menstruation ☐ Yes ☐ No ☐ N/A	If yes, please tick all body areas that apply: ☐ Face ☐ Trunk(stomach or back) ☐ Arms ☐ Legs ☐ Buttocks ☐ Toes ☐ Fingers
Swollen ankle(s) ☐ Yes ☐ No	Bleeding ☐ Yes ☐ No If yes, specify bleeding site:_____
Problems with balance ☐ Yes ☐ No	Any other NEW symptoms? ☐ Yes ☐ No If yes, specify: _____
Weakness in arms or legs ☐ Yes ☐ No / muscle weakness	

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

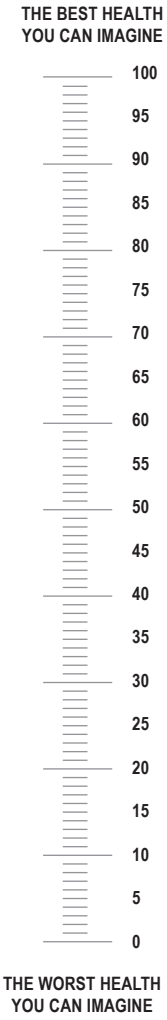
- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

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 ☐

- 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 = [ ]

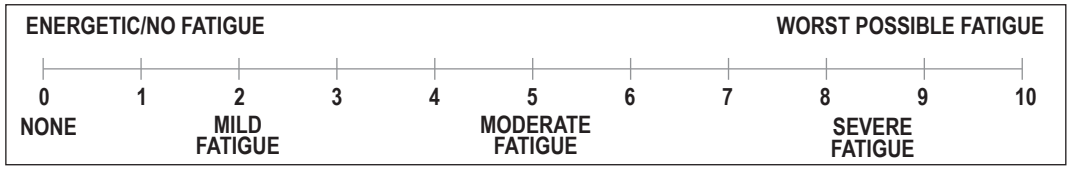


6. Breathlessness and tiredness

Please tick ONE box that best describes how breathless you feel Today	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



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)				

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

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 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:_____

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!