ISARIC 4C
Coronavirus
Clinical
Characterisation
Consortium

COVID-19 Health and Wellbeing Initial Follow Up Survey

PATIENT SELF ASSESSMENT SURVEY

The question on our minds

This is for people like you, who have had/currently have Covid-19 and are participating in the ISARIC CCP-UK study. We'd like your help to answer a question that's on our minds and may be on yours: "What does Covid mean for my health and well-being, long term?"

How you can help

This is a new illness. Being included in this short survey means you can help us build a better picture of the care and support needed after Covid. As far as possible, we don't want anyone left out. Our aim is that everyone who has had Covid-19 has a chance to take part, whether you have been treated in hospital or at home. We don't know how long people's symptoms will last so, to find out, we'd like to repeat this survey with you every three to six months over the next three years.

Completing the survey

Covid-19 affects people differently, so our survey has to cover a range of issues. Please don't worry if several questions don't feel relevant. If you feel unable to answer any, just move on to the next. Equally, if the survey highlights issues you haven't had chance to deal with, please take good care of yourself and raise them with a health professional, **please also find advice on the NHS.uk website: www.nhs.uk**

Protecting your information

In this research follow-up survey we will use information from you. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study. Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. We will make sure noone can work out who you are from the reports we write. The main ISARIC CCP-UK study information sheet tells you more about this. Please feel free to read more about the privacy policy at our website, **https://isaric4c.net/privacy** where you can also download the online version or further paper copies of this survey.

Our thanks to you, and an offer

Thank you for helping answer this important question, which is at the forefront of our minds just now. Once you've completed the survey, we'd also like to offer you the possibility to tell us more via a consultation with a nurse. We won't be able to do this for everyone, but if you'd like the chance to be included, please fill in your contact details on the next page.

ISARIC 4C Coronavirus Clinical Characterisation Consortium

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

Your permission to proceed

Thank you for coming this far. Now to take part, please read the statements below, and initial the boxes if you're happy to go ahead.

PLEASE MARK YOUR INITIALS AGAINST EACH STATEMENT WITH WHICH YOU AGREE:	*Initials:*	
I give my consent for the information I provide in this study to be used as advised.		
I give my consent for this survey to be sent to me in 3 to 6 months' time, and over the course of the next 3 years.	YES	NO
I would like the possibility to be contacted by a nurse, doctor or researcher to discuss my COVID-19 illness further If yes, please enter your telephone numbers below: Telephone: _____ Mobile phone:_____	YES	NO

About you (if you're completing this survey on behalf of a child or adult that you care for, please enter their details)

Patient's / Adult's signature

_____

Patient first name:_____Surname:_____

Postcode:_____

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

Patient's NHS number:_____ ☐ Don'tknow

Patient's Chi Number (Scotland only):_____ ☐ Don'tknow

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

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 due to COVID-19? ☐ Yes ☐ No

If admitted to hospital, were you ever admitted to intensive care (ICU/ITU)? ☐ Yes ☐ No ☐ Not applicable

Name of hospital/s: _____

2. About your health now

Do you feel fully recovered from COVID-19? ☐ Yes ☐ No ☐ Not sure

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 recent feverish illness?
☐ COVID -19 ☐ Other respiratory infection (cough/cold/sore throat)
☐ Stomach infection (diarrhoea/vomiting) ☐ Urinary infection
☐ Other: specify: _____
☐ Unknown ☐ Prefer not to say

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

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

Other condition (please specify)? _____

4. Within the last seven days, have you had any of these symptoms?

Headache	☐ Yes ☐ No	Problems with balance	☐ Yes ☐ No
Persistent cough If yes ☐ dry cough ☐ with phlegm	☐ Yes ☐ No	Weakness in limbs	☐ Yes ☐ No
Loss of smell	☐ Yes ☐ No	Pain on breathing	☐ Yes ☐ No
Loss of taste	☐ Yes ☐ No	Chest pains	☐ Yes ☐ No
Shortness of breath/ breathlessness	☐ Yes ☐ No	Palpitations (heart racing)	☐ Yes ☐ No
Persistent muscle pain	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Swollen ankle(s)	☐ Yes ☐ No	Stomach pain	☐ Yes ☐ No

Within the last seven days, have you had any of these symptoms?

Nausea/vomiting	☐ Yes	☐ No		Problems sleeping	☐ Yes ☐ No
Constipation	☐ Yes	☐ No		Lumpy lesions (purple/pink/bluish) on toes/	
Diarrhoea	☐ Yes	☐ No		COVID-toes?	☐ Yes ☐ No
Problems passing urine	☐ Yes	☐ No		Skin rash	☐ Yes ☐ No
Erectile dysfunction	☐ Yes	☐ No	☐ N/A	If yes, please tick all body areas that apply: o Face o Trunk(stomach or back) o Arms o Legs o Buttocks o Toes o Fingers	
Can't fully move and / or feel one side of your body or face ?	☐ Yes	☐ No		Any other NEW symptoms?	☐ Yes ☐ No
Dizziness/light headedness	☐ Yes	☐ No		If yes, specify: _____	
Problems swallowing or chewing	☐ Yes	☐ No		_____	
Problems seeing	☐ Yes	☐ No			

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 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

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 ☐

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

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

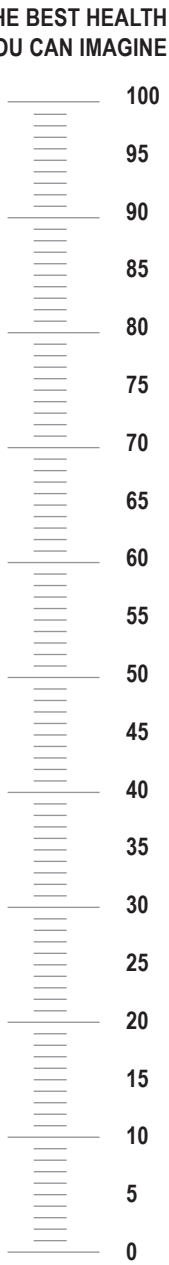
- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

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 = ☐

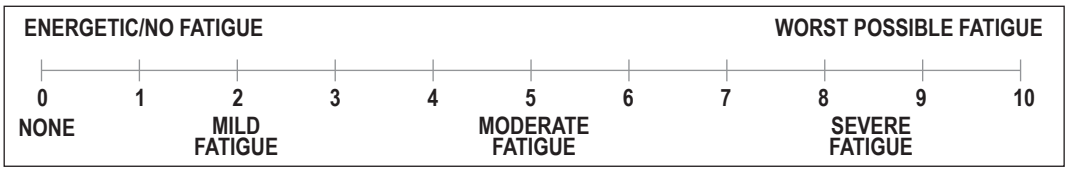


6. Breathlessness and fatigue

Please tick ONE box that describes how breathless you feel today and ONE box that describes how breathless you felt before your Covid-19 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**
1. 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
2. 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
3. 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
4. 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
5. 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
6. 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	N/A
Smoking				
Drinking alcohol				
Eating healthy food				
Physical activity (including walking & cycling)				
Walking or cycling to work or school/college				

9. A few questions about your employment status

Before you got COVID-19 what was your employment status?

☐ Full-time Employment ☐ Part time employment ☐ Furloughed
☐ 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 employment status today?

☐ Same as before ☐ Different from before ☐ Prefer not to say

If different, please describe your employment status today?

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

If different, why did you employment status change?

☐ Poor health ☐ New caring responsibility ☐ Made redundant
☐ Working hours reduced by employer ☐ 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: _____ . ____ Indicate unit measured in: ☐ cm or ☐ feet
☐ Prefer not to say

What is your current estimated weight: _____. ____ Indicate unit measured in: ☐ kg or ☐ lbs
☐ Prefer not to say

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

_____

_____

Thank you for your time!
If you have specific questions about your health please find advice on the NHS.uk website:www.nhs.uk