ISARIC 4C
Coronavirus
Clinical
Characterisation
Consortium

COVID-19 Health and Wellbeing Ongoing 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. You have already completed this survey at least once, but we'd like to see how your health and wellbeing has changed since then. Your continued help will help us 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. Remaining included in these short surveys 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 continue 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 no-one 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

Thank you for helping answer this important question, which is at the forefront of our minds just now.

ISARIC 4C Coronavirus Clinical Characterisation Consortium

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

SURVEY TIMEPOINT (to be completed by ISARIC 4C team before sending):

3m [__] 6m [__] 9m [__] 12m [__] 15m [__] 18m [__] 21m [__] 24m [__] 27m [__]30m [__] 33m [__] 36m [__]

Time point of previous surveys completed (to be completed by ISARIC 4C team before sending):

3m [__] 6m [__] 9m [__] 12m [__] 15m [__] 18m [__] 21m [__] 24m [__] 27m [__]30m [__] 33m [__] 36m [__]

1. When you completed this survey

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

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?

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 specfy)?	

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	Can't fully move and / or feel one side of your body or face ?	☐ Yes ☐ No
Loss of taste	☐ Yes ☐ No	Chest pains	☐ Yes ☐ No
Shortness of breath/ breathlessness	☐ Yes ☐ No	Palpitations (heart racing)	☐ Yes ☐ No
Pain on breathing	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
Persistent muscle pain	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Stomach pain	☐ Yes ☐ No
Swollen ankle(s)	☐ Yes ☐ No	Nausea/vomiting	☐ Yes ☐ No

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

Constipation	☐ Yes	☐ No		
Diarrhoea	☐ Yes	☐ No		
Problems passing urine	☐ Yes	☐ No		
Erectile dysfunction	☐ Yes	☐ No	☐ N/A	
Dizziness/light headedness	☐ Yes	☐ No		
Fainting/blackouts	☐ Yes	☐ No		
Problems seeing	☐ Yes	☐ No		
Problems sleeping	☐ Yes	☐ No		

Skin rash ☐ Yes ☐ No

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

Lumpy lesions (purple/pink/bluish) on toes/ COVID-toes? ☐ Yes ☐ No

Any other NEW symptoms? ☐ Yes ☐ No

If yes, specify: _____

_____

5. About your health

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

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

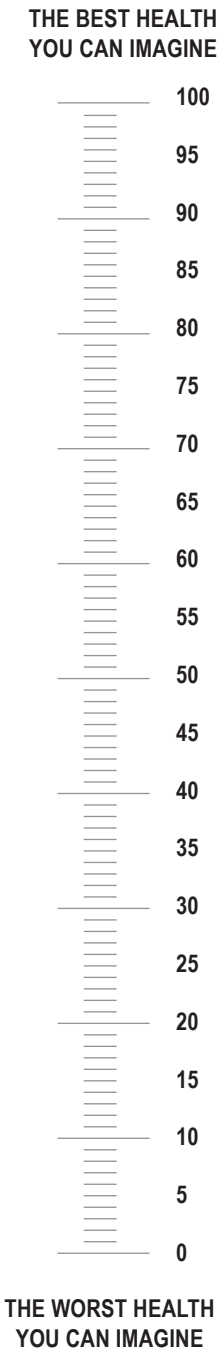
- I had no pain or discomfort ☐
- I had slight pain or discomfort ☐
- I had moderate pain or discomfort ☐
- I had severe pain or discomfort ☐
- I had extreme pain or discomfort ☐

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 ☐

- 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 = ☐

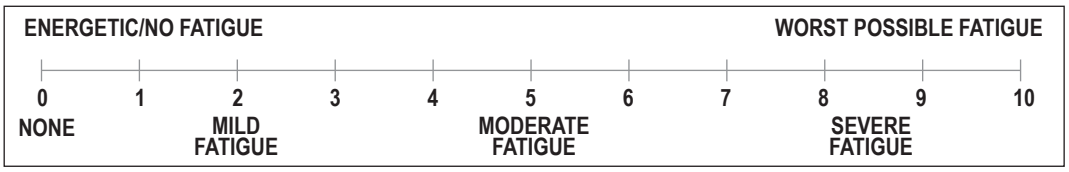


6. Breathlessness and fatigue

Please tick ONE box that best describes how breathless you feel currently (over the last 24 hours)	Within the last 24 hours (TICK ONE)
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**
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
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
3. Do you have difficulty walking or climbing steps?	☐ 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
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
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

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

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

_____

_____

11. End of survey

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