**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 in three to six months’ time.

**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**](http://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. 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.

**Your permission to proceed**

Thank you for coming this far. Now to take part, please read the statements below, tick or initial the boxes (like the example) and sign underneath the table if you’re happy to go ahead.

|  |  |  |
| --- | --- | --- |
| ***PLEASE COMPLETE THE TABLE LIKE THIS EXAMPLE, BY TICKING OR INITIALLING IN THE BOX TO INIDCATE WHETHER OR NOT YOU AGREE WITH EACH STATEMENT:*** | *YES:* | *NO:* |
| *I give my consent to take part (EXAMPLE)* | **ex** |  |
|  | | |
| ***PLEASE MARK YOUR INITIALS AGAINST EACH STATEMENT WITH WHICH YOU AGREE:*** | | |
|  | *YES:* | |
| *I confirm that I read this document and I give my consent for the information I provide in this study to be used as advised above.* |  | |
| ***OPTIONAL:*** | *YES:* | *NO:* |
| *I give my consent for ongoing follow-up surveys to be sent to me in 3 to 6 months’ time.* |  |  |
| *If* ***yes****, please indicate if you would like to receive surveys by:*  ***Post:*** *Yes □ No □*  ***Telephone:*** *Yes □ No □ (If yes please provide your telephone number/s below)*  ***E-mail:*** *Yes □ No □ (If yes please clearly write your e-mail address below (use capital letters)*  ***Contact details:***  *Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Mobile phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | |
| *I would like the possibility to be contacted by a nurse, doctor or researcher to discuss my COVID-19 illness further. We may not be able to invite everyone, please complete your contact details if you wish to be considered.* | *YES:* | *NO:* |
|  |  |
| ***If yes****, please enter your telephone numbers below:*  *Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Same as above □*  *Mobile phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Same as above □* | | |

**About you:** *Please complete your details below.*

*If the person who took part in this study about Covid-19 is not you, but someone you care for and you are completing the survey on their behalf, please complete their details instead of your own.*

***Patient’s/Adult’s/Carer’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Patient first name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s date of birth (DD/MM/YYYY):** [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

Patient’s NHS number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Don’t know

Patient’s Chi Number (Scotland only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○ Don’t know

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **About you and your COVID-19 illness This survey is aimed at people who are 18 years or older** (if you’re completing this survey on behalf of a person 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |
| 1. **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 1 to 2 weeks ago  between 2 to 4 weeks ago  between 1 to 2 months ago  between 2 to 3 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 | | | | | |
| 1. **Vaccinations** | | | | | | | | | |
| **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 vaccine dose received:** [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_2\_][\_0\_][\_2\_][\_Y\_] * **Which type of Covid-19 vaccine did you receive:**   ○ AstraZeneca (Oxford) ○ Pfizer-BioNTech ○ Janssens ○ Moderna’s ○ Other (name): \_\_\_\_\_\_\_\_ ○ Not sure  **Have you been vaccinated against influenza within last 6 months?** ○ Yes ○ No ○ Not sure | | | | | | | | | |
| 1. **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)?** | | | | |  | |
| 1. **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 | **Swollen ankle(s)** | | | | | Yes  No | |
| **Loss of taste** | | Yes  No | **Problems with balance** | | | | | Yes  No | |
| **Shortness of breath/breathlessness** | | Yes  No | **Weakness in limbs** | | | | | Yes  No | |
| **Pain on breathing** | | Yes  No | **Can’t fully move and / or feel one side of your body or face ?** | | | | | Yes  No | |
| **Chest pains** | | Yes  No | **Dizziness/light headedness** | | | | | Yes  No | |
| **Palpitations (heart racing)** | | Yes  No | **Fainting/ blackouts** | | | | | Yes  No | |
| **Weight loss** | | Yes  No | **Problems seeing** | | | | | Yes  No | |
| **Loss of appetite** | | Yes  No | **Problems sleeping** | | | | | Yes  No | |
| **Stomach pain** | | Yes  No | **Skin rash** Yes  No  **If yes, please tick all body areas that apply:**  ☐ Face ☐ Trunk(stomach or back) ☐ Arms ☐Legs ☐ Buttocks ☐Toes ☐Fingers | | | | | | |
| **Nausea/vomiting** | | Yes  No | **Lumpy lesions (purple/pink/bluish) on toes/COVID-toes?** | | | | | Yes  No | |
| **Constipation** | | Yes  No | **Fatigue** Yes  No | | | | | | |
| **Diarrhoea** | | Yes  No |
| **Problems passing urine** | | Yes  No | **Hair loss** Yes  No | | | | | | |
| **Erectile dysfunction** | | Yes  No  N/A | **Any other NEW symptoms?** Yes  No  **If yes, specify:** | | | | | | |
| 1. **About your health** © *EuroQol Research Foundation. EQ-5D™ is a trade mark of the EuroQol Research Foundation* | | | | | | | | | |
| Under each heading, please tick the ONE box that best describes your health **BEFORE COVID-19** | | | | | | | | | |
| **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* | | | | | |
| **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 = | | | | | |
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| 1. **Breathlessness and fatigue** | | | | | | | | | |
| **Please tick ONE box that best describes how breathless you feel and ONE box that describes how breathless you felt before your Covid 19 illness** | | | | | | **Within the last 24 hours** | | | **Before your Covid 19 illness** |
| 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** | | | | | | | | | |
| 1. **The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.** | | | | | | | | | |
|  | | | | **Today** | | | **Before your Covid 19 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 | | |
| 1. **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** |  | | |  |  | | | |  |
| 1. **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 ○Differentfrom 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  **Have you been on sick leave from work or college/university due to your Covid-19 illness?**  Yes  No  Prefer not to say  **If yes, for how long have you been off sick in total:** [\_Number\_] indicate unit  days weeks | | | | | | | | | |
| 1. **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: ○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 ○ stones and pounds ○Prefer not to say | | | | | | | | | |
| 1. **Please let us know if you feel COVID-19 has affected your health or wellbeing in a way not described above?** | | | | | | | | | |
|  | | | | | | | | | |
| 1. **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** | | | | | | | | | |