

Symptom Questionnaire

- acute symptoms and post COVID symptoms

Date _____
 Name (label) _____, Personal id _____ - _____

Did you experience symptoms when you first discovered you were infected/first fell ill with COVID-19?

Fill in the date of the first COVID-19 symptom / /
 (fill in the month and year if you do not remember the exact date)

Did you experience the following symptoms	X in 1 of 3 boxes			Duration of symptom in days If you still have the symptom: write "still"	Did have the symptom with the same manifestation <u>before</u> COVID-19
	Yes	No	Don't know		
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Numbness/tingling/sleeping/sensation of skin (e.g., hands/feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Impaired smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Impaired taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Confusion/(febrile) delirium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Dyspnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Expectoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Runny nose/nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Itching skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Myalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Physical exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Subjective fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ kg	
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	

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Symptoms experienced during the last 4 weeks (page 2-3)

	During the past 4 weeks, to what extent have you experienced	X in 1 of 5 boxes					Did experience the symptom with the same manifestation before COVID-19	
		None	A little	Some	A lot	Very much		
Central nervous system senses	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Numbness/tingling/sleeping/sensation of skin (e.g. hands/feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Impaired smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Impaired taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cognition	Difficulty concentrating/problems doing what you usually do mentally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficulty remembering things that have just happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficulty remembering things that happened months or years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart and lungs	Dyspnea at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dyspnea at physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	If yes, (dyspnea): Tick 1 next to the activity you experience as the worst	1: Are you ever troubled by breathlessness except on strenuous exertion? <input type="checkbox"/>						
		2: Are you short of breath when hurrying on the level or walking up a slight hill? <input type="checkbox"/>						
		3: Do you have to walk slower than most people on the level? Do you have to stop after a mile or so (or after ¼ hour) on the level at your own pace? <input type="checkbox"/>						
		4: Do you have to stop for breath after walking about 100 yds. (or after a few minutes) on the level? <input type="checkbox"/>						
		5: Are you too breathless to leave the house, or breathless after undressing? <input type="checkbox"/>						
	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Expectoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Runny nose or nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>During the past 4 weeks</u> , to what extent have you experienced	None	A little	Some	A lot	Very much	Did experience the symptom with the same manifestation <u>before</u> COVID-19
Abdomen	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Altered bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Weight loss after the acute phase of COVID-19	____ kg			Weight loss stopped <input type="checkbox"/>		
Infection	Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dont know <input type="checkbox"/>	Number of days with feber (past 4 weeks) ____		
	<u>During the past 4 weeks</u> , to what extent have you experienced	None	A little	Some	A lot	Very much	Did experience the symptom with the same manifestation <u>before</u> COVID-19
Skin	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Myalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General symptoms	Physical exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Disturbed sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Problems falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Other symptoms and worst symptom	
In association with COVID-19, have you had symptoms that are not mentioned on the previous 3 pages?	_____
Symptom/problem that is currently most bothersome after COVID-19 (affects your everyday life the most)	_____

Illness and need to contact hospital/doctor	
Admissions to hospital after the acute phase of COVID-19	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes	Diagnosis/symptom: _____ _____
Contacts to a doctor after the acute phase of COVID-19 (not the contact that gave rise to the current referral)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes	Diagnosis/symptom: _____ _____

Comments

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Work

How is your current work situation do best describe?, or your previous work situation if you are not currently working? (0 or multiple crosses possible)

- ☐ Employed ☐ Self-employed ☐ Voluntary work (unpaid)
☐ Student ☐ Stay at home ☐ Retired ☐ Newer worked

***Which of the following choices best describe your current work situation?
(tick 1-2 boxes)***

A. If employed, are you then? ☐ Full time ☐ Part time ☐ Partially recovered

B. If not employed, are you then?: ☐ Not working due to your health

☐ Not working due to other reasons: please elaborate: _____

If you are not currently working, what date did you stop? ____/____/____

What is the highest level of education you have completed? (tick 1-2 boxes)

Primary school

- ☐ Not completed primary school ☐ Primary school ☐ High school ☐ Vocational education
☐ Medium-cycle higher education ☐ University ☐ Master/PhD

What is your current or most recent job/profession (job title)?
