

Testing & Symptoms Form

We would like to ask you some questions to help us better understand symptoms related to the COVID-19 pandemic. The survey consists of nine sections. This is Section 1.

Time you began survey:

*Use military format (HH:MM) or hit the "Now" button

What is your gender?

- Male/Man
- Female/Woman
- Trans Male/Trans Man
- Trans Female/Trans Woman
- Genderqueer/Gender non-conforming
- Different identity (specify)
- Don't know
- Refuse to answer

Please specify different identity:

What is your race?

*Select all that apply

- White
- Black/African American
- East Asian American
- South Asian American
- Native American/American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Other (specify)
- Don't know
- Refuse to answer

Please specify other race:

Are you Hispanic, Latino, or of Spanish origin?

- Yes
- No
- Don't know
- Refuse to answer

Please provide the zip code where you live:

What is your year of birth?

What is the highest level of education you have completed?

- Never attended school
- Grades 1 through 8
- Grades 9 through 11/Some high school
- Grade 12/Completed high school or GED
- Some college, Associates Degree, or Technical Degree
- Bachelor's Degree
- Any post graduate studies
- Refuse to answer

We want to know your general state of health before you tested positive or had symptoms of COVID-19. How would you describe your health before you became sick with COVID-19?

- Excellent (I had no major health issues)
- Very good (I had no major health issues, but some minor ones)
- Good (I had one major health issue, but it was controlled)
- Fair (I had some major and minor health issues)
- Poor (I had several serious health issues)
- Refuse to answer

For the next set of questions, if you have been infected with COVID-19 more than once, base your responses on your first infection with COVID-19.

How many times have you been tested for COVID-19? Here we are asking about whether you have been tested for the virus itself. This is typically done with a swab that goes into your nose.

- 0 times
- 1 time
- 2-4 times
- 5-10 times
- Greater than 10 times
- Don't know
- Refuse to answer

Have you ever tested positive for COVID-19?

- No, I have NEVER tested positive
- Yes, I have tested positive one or more times
- My results are pending

You indicated above that you have never been tested for COVID-19, tested negative for COVID-19, or that your COVID-19 test results are pending. Do you know how you were exposed to COVID-19?

- I live with someone who tested positive for COVID-19.
- I have been in close contact with someone who tested positive for COVID-19.
- I do not know how I was exposed to COVID-19.
- Refuse to answer

*Select all that apply

What type of test did you take when you tested positive for COVID-19?

- PCR (also called a viral or molecular test)
- Rapid Test (also called an antigen test)
- I took both
- Don't know
- Refuse to answer

In which month did you receive your first COVID-19 positive test?

*must provide value _____ On which day did you receive your first COVID-19 positive test?

*must provide value _____ In which year did you receive your first COVID-19 positive test?

*must provide value _____

In which state or United States territory did you first test positive for COVID-19?

*If you received your first positive COVID-19 test outside of the United States, please select "Other" and you will be asked to specify the location.

- Alabama
- Alaska
- American Samoa
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Georgia
- Guam
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Northern Mariana Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virgin Islands
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming
- Other (specify)

Please specify other location where you first tested positive for COVID-19:

In which month did you first experience COVID-19 symptoms?

*must provide value _____

On which day did you first experience COVID-19 symptoms?

*must provide value _____

In which year did you first experience COVID-19 symptoms?

*must provide value _____

Have you received a flu vaccine between August 1, 2020, and the date of your first COVID-19 symptoms? As a reminder, you stated your first COVID-19 symptoms began in [symmtons] of [symyrts].

- Yes
 - No
 - Don't know
 - Refuse to answer
-

In which month did you receive the flu vaccine?

*must provide value _____

On which day did you receive the flu vaccine?

*must provide value _____

In which year did you receive the flu vaccine?

*must provide value _____

In the past five years, have you received the flu vaccine?

- Yes, every year
 - Yes, but not every year
 - Never
 - Don't know
 - Refuse to answer
-

Have you ever been given a vaccine for COVID-19 or enrolled in the COVID-19 clinical vaccine trials?

- Yes
 - No
 - Don't know
 - Refuse to answer
-

How many doses of the COVID-19 vaccine have you received to date?

- 1
 - 2
 - 3
 - Other (specify)
 - Refuse to answer
-

Please specify the other number of doses of the COVID-19 vaccine you have received to date: _____

Which COVID-19 vaccine trial or vaccine were you given as your first dose?

- Moderna mRNA vaccine
 - Pfizer mRNA vaccine
 - AstraZeneca attenuated viral vaccine
 - Johnson & Johnson
 - Novavax
 - Other (specify)
 - Don't know
 - Refuse to answer
-

Please specify other COVID-19 vaccine you were given as your first dose: _____

If you participated in the COVID-19 clinical vaccine trials, do you know if you received a placebo or the vaccine? A placebo is a harmless substance that looks like the vaccine being tested, but does not contain active ingredients.

- I received a placebo
- I received the vaccine
- I was not part of the COVID-19 clinical vaccine trials
- Don't know
- Refuse to answer

In which month did you receive the first dose of the COVID-19 vaccine?

*must provide value _____

On which day did you receive the first dose of the COVID-19 vaccine?

*must provide value _____

In which year did you receive the first dose of the COVID-19 vaccine?

*must provide value _____

Which COVID-19 vaccine trial or vaccine were you given as your second dose?

- Moderna mRNA vaccine
 - Pfizer mRNA vaccine
 - AstraZeneca attenuated viral vaccine
 - Johnson & Johnson
 - Novavax
 - Other (specify)
 - Don't know
 - Refuse to answer
-

Please specify other COVID-19 vaccine you were given as your second dose: _____

In which month did you receive or will you receive the second dose of the COVID-19 vaccine?

*must provide value _____

On which day did you receive or will you receive the second dose of the COVID-19 vaccine?

*must provide value _____

In which year did you receive or will you receive the second dose of the COVID-19 vaccine?

*must provide value _____

Which COVID-19 vaccine trial or vaccine were you given as your third dose?

- Moderna mRNA vaccine
 - Pfizer mRNA vaccine
 - AstraZeneca attenuated viral vaccine
 - Johnson & Johnson
 - Novavax
 - Other (specify)
 - Don't know
 - Refuse to answer
-

Please specify other COVID-19 vaccine you were given as your third dose: _____

In which month did you receive or will you receive the third dose of the COVID-19 vaccine?

*must provide value _____

On which day did you receive or will you receive the third dose of the COVID-19 vaccine?

*must provide value _____

In which year did you receive or will you receive the third dose of the COVID-19 vaccine?

*must provide value _____

Have you ever received a COVID-19 antibody test? A COVID-19 antibody test looks for antibodies in your blood to determine if you had a past infection with COVID-19 or have been vaccinated against COVID-19. A COVID-19 antibody test is not used to diagnose current infection.

- Yes
 - No
 - Don't know
 - Refuse to answer
-

What were the results of your COVID-19 antibody test?

- Positive, I have COVID-19 antibodies
 - Negative, I do not have COVID-19 antibodies
 - My COVID-19 antibody test results were indeterminate
 - Don't know
 - Refuse to answer
-

In which month were you tested for COVID-19 antibodies?

*must provide value _____

On which day were you tested for COVID-19 antibodies?

*must provide value _____

In which year were you tested for COVID-19 antibodies?

*must provide value _____

Have you participated in any COVID-19 treatment trials?

- Yes
- No
- Don't know
- Refuse to answer

Which COVID-19 treatment trials have you participated in?

COVID-19: Symptoms

Compared to your health before your COVID-19 illness, would you say your health is:

- 1-10% of health before COVID-19 (not recovered) 11-25% of health before COVID-19
 24-49% of health before COVID-19 50% of health before COVID-19 (half-recovered)
 51-75% of health before COVID-19 76-99% of health before COVID-19 100% of health before COVID-19 (fully recovered) Refuse to answer

When you first became ill with COVID-19, what symptoms did you initially experience?

As a reminder, you stated your symptoms began in [symptoms] of [symptoms].

*Select all that apply

- Fever >100.4oF or >38oC
- Fever but do not know exact temperature (no thermometer)
- New or worsening cough
- Sore throat
- Runny nose
- Shortness of breath
- Chills/Repeated shaking with chills
- Pneumonia/pneumonia-like symptoms
- Lack of energy or general tired feeling
- Muscle weakness
- Loss of appetite, like you just haven't been hungry
- Discomfort, tightness, or pressure in chest
- Feeling sick to your stomach or vomiting
- Diarrhea
- Muscle aches
- Joint aches
- Headache
- Seizure
- Dizziness
- Having hallucinations, altered consciousness
- Loss of ability to smell
- Altered smell
- Loss of ability to taste
- Altered taste
- Seasonal allergies
- Pain in teeth
- Hair loss (alopecia)
- Heavy limbs
- Tremors
- Rapid heart rate
- Slow heart rate
- Difficulty sleeping
- Insomnia (difficulty falling and staying asleep)
- Hypersomnia (excessive sleepiness or drowsiness)
- Disturbed sleep (nightmares, night sweats, etc.)
- Eye problems
- Prickling, burning, or numb sensation (neuropathy)
- Ringing or buzzing in ears (tinnitus)
- Skin problems
- Other symptom #1 (specify)
- Other symptom #2 (specify)
- Other symptom #3 (specify)
- Other symptom #4 (specify)
- Other symptom #5 (specify)
- Any additional symptoms (specify)
- I did not have any symptoms

Did the fever >100.4oF or >38oC affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the fever >100.4oF or >38oC cleared?

- Yes
- No
- Refuse to answer

Did the fever (where you do not know exact temperature) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the fever (where you do not know exact temperature) cleared?

- Yes
- No
- Refuse to answer

Did the new or worsening cough affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the new or worsening cough cleared?

- Yes
- No
- Refuse to answer

Did the sore throat affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the sore throat cleared?

- Yes
- No
- Refuse to answer

Did the runny nose affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the runny nose cleared?

- Yes
- No
- Refuse to answer

Did the shortness of breath affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the shortness of breath cleared?

- Yes
- No
- Refuse to answer

Did the chills/repeated shaking with chills affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the chills/repeated shaking with chills cleared?

- Yes
- No
- Refuse to answer

Did the pneumonia/pneumonia-like symptoms affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the pneumonia/pneumonia-like symptoms cleared?

- Yes
- No
- Refuse to answer

Did the lack of energy or general tired feeling affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the lack of energy or general tired feeling cleared?

- Yes
- No
- Refuse to answer

Did the muscle weakness affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the muscle weakness cleared?

- Yes
- No
- Refuse to answer

Did the loss of appetite affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the loss of appetite cleared?

- Yes
- No
- Refuse to answer

Did the discomfort, tightness, or pressure in the chest affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the discomfort, tightness, or pressure in the chest cleared?

- Yes
- No
- Refuse to answer

Did the feeling sick to your stomach or vomiting affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the feeling sick to your stomach or vomiting cleared?

- Yes
- No
- Refuse to answer

Did the diarrhea affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the diarrhea cleared?

- Yes
- No
- Refuse to answer

Did the muscle aches affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the muscle aches cleared?

- Yes
- No
- Refuse to answer

Did the joint aches affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the joint aches cleared?

- Yes
- No
- Refuse to answer

Did the headache(s) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the headache(s) cleared?

- Yes
- No
- Refuse to answer

Did the seizure(s) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the seizure(s) cleared?

- Yes
- No
- Refuse to answer

Did the dizziness affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the dizziness cleared?

- Yes
- No
- Refuse to answer

Did the hallucinations/altered consciousness affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the hallucinations/altered consciousness cleared?

- Yes
- No
- Refuse to answer

Did the loss of ability to smell affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the loss of ability to smell cleared?

- Yes
- No
- Refuse to answer

Did the altered smell affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the altered smell cleared?

- Yes
- No
- Refuse to answer

Did the loss of ability to taste affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the loss of ability to taste cleared?

- Yes
- No
- Refuse to answer

Did the altered taste affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the altered taste cleared?

- Yes
- No
- Refuse to answer

Did the seasonal allergies affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the seasonal allergies cleared?

- Yes
- No
- Refuse to answer

Did the tooth pain affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the tooth pain cleared?

- Yes
- No
- Refuse to answer

Did the hair loss (alopecia) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the hair loss (alopecia) cleared?

- Yes
- No
- Refuse to answer

Did the heavy limbs affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the heavy limbs cleared?

- Yes
- No
- Refuse to answer

Did the tremors affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the tremors cleared?

- Yes
- No
- Refuse to answer

Did the rapid heart rate affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the rapid heart rate cleared?

- Yes
- No
- Refuse to answer

Did the slow heart rate affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the slow heart rate cleared?

- Yes
- No
- Refuse to answer

Did the difficulty sleeping affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the difficulty sleeping cleared?

- Yes
- No
- Refuse to answer

Did the insomnia (difficulty falling and staying asleep) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the insomnia (difficulty falling and staying asleep) cleared?

- Yes
- No
- Refuse to answer

Did the hypersomnia (excessive sleepiness or drowsiness) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the hypersomnia (excessive sleepiness or drowsiness) cleared?

- Yes
- No
- Refuse to answer

Did the disturbed sleep (nightmares, night sweats, etc.) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the disturbed sleep (nightmares, night sweats, etc.) cleared?

- Yes
- No
- Refuse to answer

Did the eye problems affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the eye problems cleared?

- Yes
- No
- Refuse to answer

Did the prickling, burning, or numb sensation (neuropathy) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the prickling, burning, or numb sensation (neuropathy) cleared?

- Yes
- No
- Refuse to answer

Did the ringing or buzzing in ears (tinnitus) affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the ringing or buzzing in ears (tinnitus) cleared?

- Yes
- No
- Refuse to answer

Did the skin problems affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Have the skin problems cleared?

- Yes
- No
- Refuse to answer

Please specify other initial symptom #1:

Did the [initoth1] affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the [initoth1] cleared?

- Yes
 No
 Refuse to answer
-

Please specify other initial symptom #2:

Did the [initoth2] affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
 The symptom really bothered me. It was hard to do normal activities.
 The symptom was very bad. I was not able to do activities that I usually do.
 Refuse to answer
-

Has the [initoth2] cleared?

- Yes
 No
 Refuse to answer
-

Please specify other initial symptom #3:

Did the [initoth3] affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
 The symptom really bothered me. It was hard to do normal activities.
 The symptom was very bad. I was not able to do activities that I usually do.
 Refuse to answer
-

Has the [initoth3] cleared?

- Yes
 No
 Refuse to answer
-

Please specify other initial symptom #4:

Did the [initoth4] affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
 The symptom really bothered me. It was hard to do normal activities.
 The symptom was very bad. I was not able to do activities that I usually do.
 Refuse to answer
-

Has the [initoth4] cleared?

- Yes
 No
 Refuse to answer
-

Please specify other initial symptom #5:

Did the [initoth5] affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the [initoth5] cleared?

- Yes
- No
- Refuse to answer

Please specify any additional initial symptoms:

Did the [symspects] affect your ability to do your normal activities?

- I had the symptom but I could still do normal activities.
- The symptom really bothered me. It was hard to do normal activities.
- The symptom was very bad. I was not able to do activities that I usually do.
- Refuse to answer

Has the [symspects] cleared?

- Yes
- No
- Refuse to answer

Now I want you to think about symptoms you may have experienced after your initial illness. Have/had you experienced any new or continuing COVID-19 symptoms?

*Select all that apply

- New or worsening cough
- Shortness of breath
- Lack of energy or general tired feeling
- Muscle weakness
- Loss of appetite, like you just haven't been hungry
- Discomfort, tightness, or pressure in chest
- Feeling sick to your stomach or vomiting
- Diarrhea
- Muscle aches
- Joint aches
- Headache
- Seizure
- Dizziness
- Having hallucinations, altered consciousness
- Loss of ability to smell
- Altered smell
- Loss of ability to taste
- Altered taste
- Pain in teeth
- Hair loss (alopecia)
- Heavy limbs
- Tremors
- Rapid heart rate
- Slow heart rate
- Chills/Repeated shaking with chills
- Difficulty sleeping
- Insomnia (difficulty falling and staying asleep)
- Hypersomnia (excessive sleepiness or drowsiness)
- Disturbed sleep (nightmares, night sweats, etc.)
- Foggy brain
- Feeling down or depressed
- Feeling anxious
- Always feeling hot or cold (temperature dysregulation)
- Feeling dizzy or lightheaded when standing up after sitting (orthostatic hypotension)
- Eye problems
- Prickling, burning, or numb sensation (neuropathy)
- Ringing or buzzing in ears (tinnitus)
- Skin problems
- Other symptom #1 (specify)
- Other symptom #2 (specify)
- Other symptom #3 (specify)
- Other symptom #4 (specify)
- Other symptom #5 (specify)
- Any additional symptoms (specify)
- I have not experienced any new or continuing symptoms

Do you still have the new or worsening cough?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the new or worsening cough affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

-
- When did the new or worsening cough clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the shortness of breath?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the shortness of breath affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the shortness of breath clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the lack of energy or general tired feeling?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the lack of energy or general tired feeling affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the lack of energy or general tired feeling clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the muscle weakness?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the muscle weakness affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

-
- When did the muscle weakness clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the loss of appetite?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the loss of appetite affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the loss of appetite clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the discomfort, tightness, or pressure in chest?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the discomfort, tightness, or pressure in chest affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the discomfort, tightness, or pressure in chest clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the feeling sick to your stomach or vomiting?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the feeling sick to your stomach or vomiting affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

When did the feeling sick to your stomach or vomiting clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the diarrhea?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the diarrhea affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the diarrhea clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the muscle aches?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the muscle aches affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the muscle aches clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the joint aches?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the joint aches affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

-
- When did the joint aches clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the headache(s)?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the headache(s) affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the headache(s) clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the seizure(s)?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the seizure(s) affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the seizure(s) clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the dizziness?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the dizziness affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

-
- When did the dizziness clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the hallucinations, altered consciousness?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the hallucinations, altered consciousness affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the hallucinations, altered consciousness clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the loss of ability to smell?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the loss of ability to smell affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the loss of ability to smell clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the altered smell?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the altered smell affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

-
- When did the altered smell clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the loss of ability to taste?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the loss of ability to taste affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the loss of ability to taste clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the altered taste?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the altered taste affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the altered taste clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the tooth pain?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the tooth pain affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

-
- When did the tooth pain clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the hair loss (alopecia)?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the hair loss (alopecia) affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the hair loss (alopecia) clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the heavy limbs?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the heavy limbs affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the heavy limbs clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the tremors?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the tremors affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

-
- When did the tremors clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the rapid heart rate?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the rapid heart rate affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the rapid heart rate clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have the slow heart rate?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the slow heart rate affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer
-
- When did the slow heart rate clear?
- Less than 3 months after symptom started
 - Between 3 to 6 months after symptom started
 - Between 6 to 9 months after symptom started
 - Greater than 9 months after symptom started
 - Don't know
 - Refuse to answer
-
- Do you still have chills/repeated shaking with chills?
- Yes, I still have this symptom
 - Yes, I still have the symptom but it is less severe
 - Yes, I still have the symptom but it comes and goes
 - No, the symptom has cleared
-
- Does/did the chills/repeated shaking with chills affect your ability to do your normal activities?
- I have/had the symptom but I can/could still do normal activities.
 - The symptom really bothers/bothered me. It is/was hard to do normal activities.
 - The symptom is/was very bad. I am/was not able to do activities that I usually do.
 - Refuse to answer

When did the chills/repeated shaking with chills clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have difficulty sleeping?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the difficulty sleeping affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the difficulty sleeping clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the insomnia (difficulty falling and staying asleep)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the insomnia (difficulty falling and staying asleep) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the insomnia (difficulty falling and staying asleep) clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the hypersomnia (excessive sleepiness or drowsiness)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the hypersomnia (excessive sleepiness or drowsiness) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the hypersomnia (excessive sleepiness or drowsiness) clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the disturbed sleep (nightmares, night sweats, etc.)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the disturbed sleep (nightmares, night sweats, etc.) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the disturbed sleep (nightmares, night sweats, etc.) clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have foggy brain?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the foggy brain affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the foggy brain clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still feel down or depressed?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the feeling down or depressed affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the feeling down or depressed clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still feel anxious?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the feeling anxious affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the feeling anxious clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still always feel hot or cold (temperature dysregulation)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the always feeling hot or cold (temperature dysregulation) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the always feeling hot or cold (temperature dysregulation) clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still feel dizzy or lightheaded when standing up after sitting (orthostatic hypotension)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the feeling dizzy or lightheaded when standing up after sitting (orthostatic hypotension) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the feeling dizzy or lightheaded when standing up after sitting (orthostatic hypotension) clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have eye problems?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the eye problems affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the eye problems clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have the prickling, burning, or numb sensation (neuropathy)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the prickling, burning, or numb sensation (neuropathy) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the prickling, burning, or numb sensation (neuropathy) clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Do you still have ringing or buzzing in ears (tinnitus)?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the ringing or buzzing in ears (tinnitus) affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the ringing or buzzing in ears (tinnitus) clear?

- Less than 3 months after symptom started
 Between 3 to 6 months after symptom started
 Between 6 to 9 months after symptom started
 Greater than 9 months after symptom started
 Don't know
 Refuse to answer
-

Do you still have skin problems?

- Yes, I still have this symptom
 Yes, I still have the symptom but it is less severe
 Yes, I still have the symptom but it comes and goes
 No, the symptom has cleared
-

Does/did the skin problems affect your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
 The symptom really bothers/bothered me. It is/was hard to do normal activities.
 The symptom is/was very bad. I am/was not able to do activities that I usually do.
 Refuse to answer
-

When did the skin problems clear?

- Less than 3 months after symptom started
 Between 3 to 6 months after symptom started
 Between 6 to 9 months after symptom started
 Greater than 9 months after symptom started
 Don't know
 Refuse to answer
-

Please specify other new or continued symptom #1:

Do you still have the [othperspec1]?

- Yes, I still have this symptom
 Yes, I still have the symptom but it is less severe
 Yes, I still have the symptom but it comes and goes
 No, the symptom has cleared
-

Does/did the [othperspec1] your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
 The symptom really bothers/bothered me. It is/was hard to do normal activities.
 The symptom is/was very bad. I am/was not able to do activities that I usually do.
 Refuse to answer
-

When did the [othperspec1] clear?

- Less than 3 months after symptom started
 Between 3 to 6 months after symptom started
 Between 6 to 9 months after symptom started
 Greater than 9 months after symptom started
 Don't know
 Refuse to answer
-

Please specify other new or continued symptom #2:

Do you still have the [othperspec2]?

- Yes, I still have this symptom
 Yes, I still have the symptom but it is less severe
 Yes, I still have the symptom but it comes and goes
 No, the symptom has cleared

Does/did the [othperspec2] your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the [othperspec2] clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Please specify other new or continued symptom #3:

Do you still have the [othperspec3]?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the [othperspec3] your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the [othperspec3] clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Please specify other new or continued symptom #4:

Do you still have the [othperspec4]?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the [othperspec4] your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the [othperspec4] clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Please specify other new or continued symptom #5:

Do you still have the [othperspec5]?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the [othperspec5] your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the [othperspec5] clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Please specify any additional new or continued symptoms:

Do you still have the [othperspec]?

- Yes, I still have this symptom
- Yes, I still have the symptom but it is less severe
- Yes, I still have the symptom but it comes and goes
- No, the symptom has cleared

Does/did the [othperspec] your ability to do your normal activities?

- I have/had the symptom but I can/could still do normal activities.
- The symptom really bothers/bothered me. It is/was hard to do normal activities.
- The symptom is/was very bad. I am/was not able to do activities that I usually do.
- Refuse to answer

When did the [othperspec] clear?

- Less than 3 months after symptom started
- Between 3 to 6 months after symptom started
- Between 6 to 9 months after symptom started
- Greater than 9 months after symptom started
- Don't know
- Refuse to answer

Have you been newly diagnosed by a physician with any of the following since exhibiting COVID-19 symptoms or since a positive COVID-19 test

*Select all that apply

- Myocarditis (inflammation of the heart muscle)
- Pericarditis (inflammation of the sac around the heart)
- Cardiomyopathy (disease of the heart muscle)
- Tachycardia (rapid heart rate)
- Atrial fibrillation (quivering or irregular heart beat)
- Pulmonary embolism (blood clot in the lung)
- Type 1 Diabetes (juvenile diabetes, insulin dependent diabetes)
- Type 2 Diabetes (insulin resistant diabetes)
- Stroke
- Blood clot (outside the lung)
- Irritable Bowel Syndrome (chronic cramping, diarrhea, gas, bloating)
- Irritable Bowel Disorder (inflammation of the intestines)
- Multiple sclerosis
- Hypothyroid (low thyroid levels)
- Hyperthyroid (high thyroid levels)
- Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)
- POTS (postural orthostatic tachycardia syndrome)
- Acute kidney disease
- Peripheral neuropathy
- Other (specify)
- None
- Don't know
- Refuse to answer

Please specify other newly diagnosed condition:

Thank you for completing Section 1. Onto Section 2!

Date Baseline Testing & Symptoms Form Completed:

Treatments & Hospitalization Form

Welcome to Section 2. After this, only seven more sections to go!

Have you ever taken any medications for the treatment of COVID-19?

- Yes
 No
 Don't know
 Refuse to answer

Were they prescribed to you by a health care provider?

- Yes
 Yes, I took both medications that were and were not prescribed by a health care provider.
 No
 Don't know
 Refuse to answer

Which medications have you taken for the treatment of COVID-19?

*Select all that apply

- Monoclonal antibody (Bamlanivimab)
 Lopinavir/Ritonavir (Kaletra)
 Hydroxychloroquine (Plaquenil)
 Hydroxychloroquine (Plaquenil) with azithromycin (Z-pak)
 Chloroquine
 Ribavirin, also known as Moderiba or Rebetol
 Remdesivir
 Azithromycin (Z-pak)
 Oseltamivir (Tamiflu)
 Blood from someone who was previously infected (convalescent plasma)
 Vitamin C
 Vitamin D
 Zinc
 Steroids
 Other (specify)
 Don't know
 Refuse to answer

Please specify other medications taken to treat COVID-19:

Since February 1, 2020, have you been hospitalized for COVID-19 or because you had difficulty breathing or because you had a respiratory infection?

- Yes
 No
 Refuse to answer

When hospitalized, were you in any of the following places?

*Select all that apply

- Emergency room, ER
 General hospital floor
 Intensive care unit, ICU
 Don't know
 Refuse to answer

How many days were you hospitalized?

*If you went to the emergency room only and did not get admitted, enter 0. If you don't know how many days you were hospitalized, enter 97. If you refuse to answer, enter 98.

_____ (days)

When hospitalized, did you require any of the following?

*Select all that apply

- Supplemental oxygen
- Ventilator support
- Neither
- Don't know
- Refuse to answer

Thank you for completing Section 2. Onto Section 3!

Date Baseline Treatments & Hospitalizations Form Completed: _____

Comorbidities Form

Welcome to Section 3! After this, only six more sections to go!

How would you describe your current health status?

- You are fully recovered
 You are not fully recovered, but you can do your usual activities
 You are recovering, but not able to do your daily activities
 You do not feel like you are recovering
 Don't know
 Refuse to answer

Before COVID-19, did you have any of the following health conditions?

*Select all that apply

- Diabetes
 Cardiovascular/heart disease
 History of heart attack
 History of congestive heart failure
 High blood pressure
 High cholesterol
 History of stroke
 Autoimmune disorder (specify)
 HIV
 Hepatitis C
 Asthma/reactive airway disease
 Chronic lung disease (COPD, emphysema, etc.)
 Chronic kidney disease
 Cancer diagnosis
 Depression
 Pregnant
 Overweight or obese
 Anxiety or other mental health condition
 Chronic or Acute Lyme disease
 Other (specify)
 None
 Refuse to answer

Please specify other health condition you had before COVID-19:

Please specify autoimmune disorder:

When was the most recent primary cancer diagnosed?

- Less than one year ago
 1-2 years ago
 2-5 years ago
 5-10 years ago
 More than 10 years ago
 Don't know
 Refuse to answer

Please specify type of cancer:

*For example, breast cancer, prostate cancer, lung cancer, etc. If you don't know, enter 97. If you refuse to answer, enter 98.

What cancer treatments are you or did you undergo?

*Select all that apply

- Chemotherapy
- Hormone therapy
- Immunotherapy
- Radiation
- Surgery
- No treatment
- Don't know
- Refuse to answer

What is your height? (feet and inches)

- 4' 0" or 48 inches
- 4' 1" or 49 inches
- 4' 2" or 50 inches
- 4' 3" or 51 inches
- 4' 4" or 52 inches
- 4' 5" or 53 inches
- 4' 6" or 54 inches
- 4' 7" or 55 inches
- 4' 8" or 56 inches
- 4' 9" or 57 inches
- 4' 10" or 58 inches
- 4' 11" or 59 inches
- 5' 0" or 60 inches
- 5' 1" or 61 inches
- 5' 2" or 62 inches
- 5' 3" or 63 inches
- 5' 4" or 64 inches
- 5' 5" or 65 inches
- 5' 6" or 66 inches
- 5' 7" or 67 inches
- 5' 8" or 68 inches
- 5' 9" or 69 inches
- 5' 10" or 70 inches
- 5' 11" or 71 inches
- 6' 0" or 72 inches
- 6' 1" or 73 inches
- 6' 2" or 74 inches
- 6' 3" or 75 inches
- 6' 4" or 76 inches
- 6' 5" or 77 inches
- 6' 6" or 78 inches
- 6' 7" or 79 inches
- 6' 8" or 80 inches
- 6' 9" or 81 inches
- 6' 10" or 82 inches
- 6' 11" or 83 inches
- Other (specify)
- Don't know
- Refuse to answer

Please specify other height:

_____ (feet' inches")

What is your weight? (pounds)

*Please round to the nearest whole number.

_____ (pounds)

Thank you for completing Section 3. Onto Section 4!

Date Baseline Comorbidities Form Completed:

Welcome to Section 4. After this, only five more sections to go!

Before COVID-19, were you limited in any way in any activities because of physical, mental, or emotional problems?

- Yes (specify)
- No
- Refuse to answer

Please specify how you were limited before COVID-19:

Before COVID-19, did you have any health problem that required you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

- Yes
- No
- Refuse to answer

*Include occasional use or use in certain circumstances

Do you have any difficulty walking a quarter of a mile, that is about 2 or 3 blocks, without stopping?

- Yes
- No
- Refuse to answer

How much difficulty do you have walking a quarter of a mile?

- A little
- Some
- A lot
- Unable to do
- Refuse to answer

Did you have difficulty walking a quarter of a mile before your COVID-19 illness?

- Yes
- No
- Refuse to answer

How easy is it for you to walk a quarter of a mile?

- Very easy
- Somewhat easy
- Not so easy
- Refuse to answer

Do you have any difficulty walking a distance of one mile?

- Yes
- No
- Refuse to answer

Did you have difficulty walking one mile before your COVID-19 illness?

- Yes
- No
- Refuse to answer

How easy is it for you to walk one mile?

- Very easy
- Somewhat easy
- Not so easy
- Refuse to answer

Do you have any difficulty walking up 10 steps, that is about 1 flight, without resting?

- Yes
- No
- Refuse to answer

How much difficulty do you have walking up 10 steps?

- A little
- Some
- A lot
- Unable to do
- Refuse to answer

Did you have difficulty walking up 10 steps before your COVID-19 illness?

- Yes
- No
- Refuse to answer

How easy is it for you to walk up 10 steps?

- Very easy
- Somewhat easy
- Not so easy
- Refuse to answer

Do you have any difficulty walking up 20 steps, that is about 2 flights, without resting?

- Yes
- No
- Refuse to answer

Did you have difficulty walking up 20 steps before your COVID-19 illness?

- Yes
- No
- Refuse to answer

How easy is it for you to walk up 20 steps?

- Very easy
- Somewhat easy
- Not so easy
- Refuse to answer

Do you have difficulty doing light housework such as doing dishes, straightening up or light cleaning by yourself?

- Yes
- No
- Refuse to answer

How much difficulty do you have doing light housework?

- A little
- Some
- A lot
- Unable to do
- Refuse to answer

Did you have difficulty doing light housework before your COVID-19 illness?

- Yes
- No
- Refuse to answer

Do you have difficulty doing heavy housework such as vacuuming and washing windows, walls, or floors?

- Yes
- No
- Refuse to answer

How much difficulty do you have doing heavy housework?

- A little
- Some
- A lot
- Unable to do
- Refuse to answer

Did you have difficulty doing heavy housework before your COVID-19 illness?

- Yes
- No
- Refuse to answer

Prior to your initial COVID-19 illness, during a typical 7-day period (a week), how many times on average did you do the following kinds of exercise for more than 15 minutes during your free time?



Strenuous exercise (heart beats rapidly)?

Examples: running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling

_____ (times per week)

Moderate exercise (not exhausting)?

Examples: fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing

_____ (times per week)

Mild/light exercise (minimal effort)?

Examples: yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking

_____ (times per week)

Since your initial COVID-19 illness, during a typical 7-day period (a week), how many times on average do you do the following kinds of exercise for more than 15 minutes during your free time?

Strenuous exercise (heart beats rapidly)?

Examples: running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling

_____ (times per week)

Moderate exercise (not exhausting)?

Examples: fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing

_____ (times per week)

Mild/light exercise (minimal effort)?

Examples: yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking

_____ (times per week)

Thank you for completing Section 4. Onto Section 5!

Date Baseline Limitations Form Completed:

Sleep Quality Form

Welcome to Section 5. After this, only four more sections to go!



- 1) How many total hours do you sleep in a typical 24 hour period? _____

*If you don't know, enter 97. If you refuse to answer, enter 98.

How often during the last four weeks did you...

- | | All of the time | Most of the time | A good bit of the time | Some of the time | A little bit of the time | None of the time | Refuse to answer |
|---|-----------------------|-----------------------|------------------------|-----------------------|--------------------------|-----------------------|---|
| 2) Get enough sleep to feel rested upon waking in the morning? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3) Have trouble falling asleep? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4) Awaken during your sleep time and have trouble falling asleep again? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5) Have trouble staying awake during the day? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6) Get the amount of sleep you need? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7) When circumstances require that you get up at a particular time in the morning (for example for work or studies, or to take the children to school during the week), do you feel that you have not had enough sleep? | | | | | | | <input type="radio"/> Always
<input type="radio"/> Often
<input type="radio"/> Sometimes
<input type="radio"/> Never
<input type="radio"/> Refuse to answer |
| 8) Is it extremely difficult for you, or even impossible, to wake in the morning without several alarm calls or the help of someone close? | | | | | | | <input type="radio"/> Always
<input type="radio"/> Often
<input type="radio"/> Sometimes
<input type="radio"/> Never
<input type="radio"/> Refuse to answer |
| 9) After a night's sleep, how long does it take you to feel you are functioning properly after you get up (in other words fully functional, both physically and intellectually)? | | | | | | | <input type="radio"/> 2 hours or more
<input type="radio"/> More than 1 hour but less than 2 hours
<input type="radio"/> Between 30 minutes and 1 hour
<input type="radio"/> Less than 30 minutes
<input type="radio"/> I feel I am functioning properly as soon as I wake up
<input type="radio"/> Refuse to answer |
| 10) During the day, while carrying out activities that are not very stimulating, do you ever struggle to stay awake? | | | | | | | <input type="radio"/> Very often (at least twice a day)
<input type="radio"/> Often (4-7 times a week)
<input type="radio"/> Sometimes (2-3 times a week)
<input type="radio"/> Rarely (once a week or less)
<input type="radio"/> Never
<input type="radio"/> Refuse to answer |

Thank you for completing Section 5. Onto Section 6!

11) Date Baseline Sleep Quality Form Completed:

Cognition Form

Welcome to Section 6. After this, only three more sections to go!



Over the last 2 weeks, how much have you been bothered by?


	Not at all	A little	Somewhat	Quite a lot	Very Much	Don't know	Refuse to answer
Spells of confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts getting mixed up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can't easily make decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor memory for recent events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can't take things in when speaking to people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts are slow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muzzy head (like a hangover)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can't find right words	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for completing Section 6. Onto Section 7!

Date Baseline Cognition Form Completed:

Anxiety Form

Welcome to Section 7. After this, only two more sections to go!

Over the last 2 weeks, how often have you been bothered by the following problems? 

	Not at all	Several days	More than half the days	Nearly every day	Don't know	Refuse to answer
Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
- Refuse to answer

Thank you for completing Section 7. Onto Section 8!

Date Baseline Anxiety Form Completed: _____

Demographics Form

Welcome to Section 8. After this, only one more section to go!

Which of the following options best describes your activities related to work, school, or home before the novel COVID-19 pandemic may have affected your work (before February 1, 2020)? This includes both formal and informal employment. Were you:

*Select all that apply

- Employed full-time (30 hours or more per week)
- Employed part-time (Less than 30 hours per week)
- Self-employed
- Full-time student
- Part-time student
- Unemployed
- Unable to work for health reasons
- Stay at home parent/guardian for child or sibling
- Active military
- Retired
- Other (specify)
- Refuse to answer

Please specify other activities related to work, school, or home: _____

Please select your primary occupation. If your primary occupation is not listed, select "Other" and specify.

- Health care worker (hospital)
- Health care worker (community)
- Nursing home
- Teacher (K-12)
- Fire/Police/State trooper/EMT
- Military
- Transportation (bus, train, light rail, uber, etc.)
- Hotel staff
- Cleaning (office/home)
- Cleaning (hospital)
- Military
- Bar tender/Restaurant server/Host
- Other (specify)
- Refuse to answer

Please specify other primary occupation: _____

What was your household income in 2019 (the year before COVID-19) from all sources before taxes? This includes all income from both formal and informal employment.

- Monthly income: \$0 to \$833; Yearly income: \$0 to \$9,999
- Monthly income: \$834 to \$1,250; Yearly income: \$10,000 to \$14,999
- Monthly income: \$1,251 to \$2,082; Yearly income: \$15,000 to \$24,999
- Monthly income: \$2,083 to \$2,916; Yearly income: \$25,000 to \$34,999
- Monthly income: \$2,917 to \$4,167; Yearly income: \$35,000 to \$49,999
- Monthly income: \$4,168 to \$6,249; Yearly income: \$50,000 to \$74,999
- Monthly income: \$6,250 or more; Yearly income: \$75,000 or more
- Don't know
- Refuse to answer

Including yourself, how many people depend on this income?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 or more
- Refuse to answer

Is there anything else about your experience with COVID-19 you would like to share with the research team?

Thank you for completing Section 8. Onto Section 9!

Date Baseline Demographics Form Completed:
