

Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid integration of a PhenX protocol into a study. The PhenX DCW is not designed to be a data collection instrument. Investigators will need to decide the best way to collect data for the PhenX protocol in their study. Variables captured in the DCW, along with variable names and unique PhenX variable identifiers, are included in the PhenX Data Dictionary (DD) files.

1. We are interested in whether you have experienced any symptoms listed below since November 2019. Please complete the table for any of the symptoms you have had and in what month(s) you had them. Please complete for any symptoms and any months that symptoms were experienced irrespective of whether or not you saw a doctor and irrespective of whether or not you were told you had flu, or coronavirus disease 2019 (COVID-19) or any other diagnosis

	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	Last week
No cold or flu symptoms							
Decrease in appetite							
Nausea and/or vomiting							
Diarrhoea							
Abdominal pain/tummy ache							
Runny nose							
Sneezing							

Blocked nose							
Sore eyes							
Loss of sense of smell							
Loss of sense of taste							
Sore throat							
Hoarse voice							
Headache (if more often or worse than usual)							
Dizziness							
Shortness of breath affecting normal activities							
New persistent cough							
Tightness in the chest							
Chest pain							
Fever (feeling too hot)							
Chills (feeling too cold)							

Difficulty sleeping							
Felt more tired than normal							
Severe fatigue (e.g. inability to get out of bed)							
Numbness or tingling somewhere in the body							
Feeling of heaviness in arms or legs							
Achy muscles							

2. If you have had any of the symptoms above in the last week:

2a. when did the first one start?

1 day ago

2 days ago

3 days ago

4 days ago

5 days ago

6 days ago

7 days ago

Can't remember

2b. when did the last one finish?

- 1 day ago
- 2 days ago
- 3 days ago
- 4 days ago
- 5 days ago
- 6 days ago
- 7 days ago
- Can't remember
- I still have it/them

2c. In the last week have you had shortness of breath (difficulty breathing)?

- No
- Yes, but did not affect my normal activities
- Yes, did affect my normal activities (e.g. walking short distances)
- Yes, even when I was sat or lying down

2d. Did you seek medical attention for the symptoms you had in the last week?

- Yes
- No

If 2d = No, skip to question 3

2e. If yes, what kind of medical attention did you access? [tick all that apply]

- Contacted NHS 111, by phone or online
- Visited pharmacist
- Consulted GP/practice nurse over the phone or online
- Consulted GP/practice nurse face to face
- Walk-in centre
- Accident and Emergency

Other, please specify _____

3.

3a. In the last week have you had your temperature taken?

Yes

No

If 3a = No, skip to question 4

3b. Who took your temperature?

A doctor/nurse or other health professional

I did

It was taken by someone else

3c. If you can remember, what was the highest temperature reading?

__ . __ C

4. Have you been in close contact with anyone with COVID-19 in the last two weeks?

Yes, I was in contact with a confirmed/tested COVID-19 case

Yes, I was in contact with a suspected COVID-19 case

No, not to my knowledge

5.

5a. Do you think that you have or have had COVID-19?

Yes, confirmed by a positive test

Yes, suspected by a doctor but not tested

Yes, my own suspicions

No

If 5a = No, go to question 6

5b. If yes, when were you told/when did you think you first had COVID-19?

__ / __ / ____ (DD/MM/YY)

6.

6a. Are you, or do you, currently have any of the following? (tick all that apply)

	Tick if yes
Organ transplant recipient	
Diabetes (Type I or II)	
Heart disease or heart problems	
Hypertension (high blood pressure)	
Overweight	
Stroke	
Kidney disease	
Liver disease	
Anaemia	
Asthma	
Other lung condition such as COPD, bronchitis or emphysema	
Cancer	
Condition affecting the brain and nerves (e.g.	

Dementia, Parkinson's, Multiple Sclerosis)	
A weakened immune system/reduced ability to deal with infections (as a result of a disease or treatment)	
Depression	
Anxiety	
Psychiatric disorder	

6b. If yes, please tell us exactly what you have:

6c. Have you been contacted by letter or text message to say you are at severe risk from COVID-19 due to an underlying health condition and should be shielding (avoiding exposure)?

1 Yes

2 No

7. For each of the following questions please respond Yes or No

	Yes	No
In general, do you have health problems that require you to limit your activities?		
Do you need someone to help you on a regular basis?		
In general, do you have any health problems that require you to stay at home?		
If you need help, can you count on someone close to		

you?		
Do you regularly use a stick, walker or wheelchair to move about?		

8. Do you currently take any regular medication?

Yes

No

9. Have you had a flu jab (flu shot) in the last 12 months?

Yes

No

Protocol source: <https://www.phenxtoolkit.org/protocols/view/940101>