



## 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.

### Memory Symptoms

1. Have you experienced any **MEMORY RELATED SYMPTOMS** since the start of your COVID-19 illness?

Yes

No

2. Which of the following memory symptoms have you experienced since the start of your COVID-19 illness?

Short-term memory loss (memory that lasts ~30 seconds, i.e. remembering a phone number before writing it down, or forgetting you're in the middle of a task)

Long-term memory loss (long-term memory can be anything from remembering yesterday, forgetting you've done a task, forgetting recently learned information, or forgetting your third-grade experience)

Not being able to make new memories

Forgetting how to do routine tasks (tying your shoe laces, washing your hands)

None of the above

Other \_\_\_\_\_

3. When did you experience these symptoms?

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

Week Week Week Week Month Month Month Month Month Month

1 2 3 4 2 3 4 5 6 7

Memory symptoms

#### Cognitive Function/Brain Fog Symptoms

4. Have you experienced issues with BRAIN FOG (inability to focus, think clearly, plan, process, understand, and maintain a coherent stream of thought; abnormally slow or fast thoughts) since the start of your COVID-19 illness?

Yes

No

5. Which of the following brain fog/cognitive functioning symptoms have you experienced since the start of your COVID-19 illness?

Difficulty with executive functioning (planning, organizing, figuring out the sequence of actions, abstracting)

Agnosia (failure to recognize or identify objects despite intact sensory functioning)

Difficulty problem-solving or decision-making

Difficulty thinking

Thoughts moving too quickly

Slowed thoughts

Poor attention or concentration

I did NOT have any Brain Fog symptoms

Other

6. When did you experience these symptoms?

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week	Week	Week	Week	Month	Month	Month	Month	Month	Month
	1	2	3	4	2	3	4	5	6	7
Brain fog/cognitive functioning symptoms	<input type="checkbox"/>									

Changes to Daily/Functional Abilities due to memory loss or brain fog

7. Have you felt significantly limited or unable to do any of the following due to **MEMORY LOSS OR BRAIN FOG** (including issues with attention, cognitive functioning, and awareness) specifically?

Severely Moderately Mildly      Not  
unable    unable      unable      Able  
   applicable

Drive

Watch children

Cook or use hot items

Feed yourself

Shower or bathe regularly

Make serious decisions

Leave the house and return without getting lost

Remember the correct month or year

Have conversations with others

Maintain your medication schedule (forgetting to take medication or forgetting you've taken medication)

Work

Follow simple instructions

Communicate your thoughts and needs

Other:

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8. Optional: If you have other areas of your life that were affected by memory loss or brain fog, please include them here. Please note whether they were mildly, moderately, or severely limiting.

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9. Optional: Please use this space to describe examples of your brain fog, memory loss, and attention span.

Please do not include any identifying information (such as name or location).

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Protocol source: <https://www.phenxtoolkit.org/protocols/view/992002>