Background Section

When did your symptoms begin? *

<table>
<thead>
<tr>
<th>Please Select:</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2020</td>
</tr>
</tbody>
</table>

Are you still experiencing symptoms? *

- ☐ Yes
- ☐ No
Recovered - Total Days

How many days total did you experience symptoms? *

Lifestyle & Pre-existing Conditions

Did you have any of these pre-existing conditions/diagnoses or did you experience any of the following pre-COVID?

- Food Allergies
- Environmental Allergies (dust, mold)
- Chemical Allergies
- Seasonal Allergies
- Allergies of unknown origin
- Other allergies
- Insomnia
- Lucid dreams (dreams where you are aware you are dreaming or have some control over what you dream)
- Nightmares
- Vivid dreams
- Night sweats
- Sleep apnea
- Acid Reflux Disease
- Celiac Disease
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Irritable Bowel Syndrome (IBS)
☐ Other GI issues
☐ Asthma
☐ COPD
☐ Tuberculosis
☐ Eczema
☐ Viral skin conditions (cold sores, herpes, warts, molluscum)
☐ Dementia
☐ Seizures/epilepsy
☐ Migraine
☐ ALS
☐ Parkinson's disease
☐ Multiple Sclerosis
☐ Peripheral neuropathy
☐ Coronary Heart Disease
☐ Heart failure
☐ Hypertension (high blood pressure)
☐ Hypotension (low blood pressure)
☐ History of clotting
☐ History of strokes
☐ High cholesterol / hyperlipidemia
☐ Mitral valve prolapse
☐ Anemia
☐ Autism
☐ Auto-immune/rheumatological conditions
☐ Cancer (all types)
☐ Chronic kidney disease
☐ Diabetes Type 1
☐ Diabetes Type 2
Please indicate other pre-existing conditions/diagnoses not listed here. If multiple, please separate them with a comma. Please only list the conditions, no descriptions or explanations.

Did any of your pre-existing conditions change during the course of
your COVID19 symptoms?

- Yes, they got worse.
- Yes, they got better.
- Some got better, some stayed the same, some got worse (please add an explanation in the text boxes in the following page).
- No, they stayed the same.
- N/A (I did not have any pre-existing condition)

If any of your pre-existing conditions got worse, please describe here. (optional)

If any of your pre-existing conditions got better, please describe here. (optional)

What is your blood type? If you don't know, please select 'Don't know'. *

[Don't know]