The Symptom Burden Questionnaire™ for Long COVID (SBQ™-LC) asks for your views about your symptoms and their impact on daily life over the last 7 days.

It will take approximately 15-20 minutes to complete all the scales.

For each scale, please answer ALL the questions. Please rest and take breaks if needed.

Thank you for completing this questionnaire.
**BREATHING**

These questions are about your BREATHING symptoms. For each question, please choose the response that best describes your experience over the last 7 days.

In the last 7 days, how severe was your shortness of breath (difficulty breathing) when sitting at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your shortness of breath (difficulty breathing) when climbing a flight of stairs at its worst?

***Response scale removed***

In the last 7 days, how severe was your shortness of breath (difficulty breathing) when lying flat at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

---

Please go to the next page
In the last 7 days, did you wake up at night short of breath?

- 0 - No
- 1 - Yes

In the last 7 days, was your breathing faster than usual?

- 0 - No
- 1 - Yes

In the last 7 days, how severe was the tightness of your chest at its worst?

***Response scale removed***

In the last 7 days, how severe was your wheezing (noisy breathing) at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

Breathing Scale Raw Score:
PAIN

These questions are about your PAIN symptoms. For each question, please choose the response that best describes your experience over the last 7 days.

In the last 7 days, how severe was your chest pain at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your pain on breathing at its worst?

***Response scale removed***

In the last 7 days, how severe was your shooting or stabbing pain in any place on your body at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your aching or burning pain in any place on your body at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

---

Pain Scale Raw Score: [ ]
CIRCULATION

These questions are about your CIRCULATION symptoms. For each question, please choose the response that best describes your experience over the last 7 days.

In the last 7 days, how severe were your palpitations (feeling like your heart skipped a beat or a pounding heartbeat) at their worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, did you feel faint?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, how severe was your dizziness on standing at its worst?

*** Response scale removed***

In the last 7 days, how severe was the swelling of your legs and/or feet at its worst?

In the last 7 days, did you have cold hands/feet that lasted for longer or were colder than usual?

- [ ] 0 - No
- [ ] 1 - Yes

Circulation Scale Raw Score:
FATIGUE

These questions are about your FATIGUE symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your fatigue (feeling of physical or mental exhaustion that does not improve with rest) at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

In the last 7 days, how severe was your low energy (being interested and wanting to do things but 1 - Yest having the energy)?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

In the last 7 days, how severe was your tiredness (need for sleep) at its worst?

***Response scale removed***

In the last 7 days, how severe was the worsening of your symptoms following simple physical or mental activities at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

Fatigue Scale Raw Score:
MEMORY, THINKING AND COMMUNICATION

These questions are about your MEMORY, THINKING, AND COMMUNICATION symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your difficulty remembering things at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

In the last 7 days, how severe was your memory loss at its worst?

***Response scale removed***

In the last 7 days, how severe was your brain fog (feeling sluggish, jet-lagged, or blanking out) at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

In the last 7 days, how often did you feel confused about what was happening around you?

- □ 0 - Never
- □ 1 - Rarely
- □ 2 - Sometimes
- □ 3 - Always

In the last 7 days, how often did you have difficulty concentrating?

- □ 0 - Never
- □ 1 - Rarely
- □ 2 - Sometimes
- □ 3 - Always

Please go to the next page
In the last 7 days, how severe was your **difficulty planning** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your **word-finding difficulty** (unable to think of the word you want to say or write) at its worst?

***Response scale removed***

In the last 7 days, how severe was your **difficulty understanding what others were saying** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your **slurred speech** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your **reading difficulty (not related to dyslexia)**?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

---

**Memory, Thinking & Communication Scale Raw Score:**
MOBEMENT

These questions are about your MOVEMENT symptoms. Please answer ALL the
questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your tremor (uncontrollable shaking or trembling in
part of your body) at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

In the last 7 days, how severe was your balance difficulty at its worst?

***Response scale removed***

In the last 7 days, how severe was your difficulty with movement and coordination at its
worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

Movement
Scale Raw Score:  

---
SLEEP

These questions are about your SLEEP symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how often did you have problems falling asleep?

☐ 0 - Never  ☐ 1 - Rarely  ☐ 2 - Sometimes  ☐ 3 - Always

In the last 7 days, how often was your sleep shorter than usual?

***Response scale removed***

In the last 7 days, how often was your sleep interrupted?

☐ 0 - Never  ☐ 1 - Rarely  ☐ 2 - Sometimes  ☐ 3 - Always

In the last 7 days, how often did you sleep longer than usual?

☐ 0 - Never  ☐ 1 - Rarely  ☐ 2 - Sometimes  ☐ 3 - Always

Sleep Scale Raw Score:
EARS, NOSE AND THROAT

These questions are about your EAR, NOSE, AND THROAT symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your altered sense of smell (foods/objects smelling different to usual) at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

In the last 7 days, how severe was your altered sense of taste (foods tasting different to usual) at its worst?

***Response scale removed***

In the last 7 days, how severe was your sneezing at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

In the last 7 days, how severe was your stuffy or runny nose at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

In the last 7 days, how severe was your sinus congestion (discomfort or feeling of 'fullness' around nose, cheeks, forehead, or around the eyes) at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

Please go to the next page
In the last 7 days, how severe was your **production of mucus (phlegm)** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your **cough** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your **sore throat** at its worst?

***Response scale removed***

In the last 7 days, how severe was your **hoarse voice (change in your voice quality)** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, did you have **difficulty swallowing food or drink**?

- 0 - No
- 1 - Yes

In the last 7 days, how severe was your **earache (ear pain)** at its worst

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

Please go to the next page
In the last 7 days, did you have *new hearing loss*?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, how severe was your **tinnitus (noises or ringing sounds in your ears)** at its worst?

***Response scale removed***

In the last 7 days, how severe was your **sensitivity to sounds that were not a problem for others (everyday sounds were uncomfortably loud and/or painful)** at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

---

**Ears, Nose & Throat Scale Raw Score:**
STOMACH AND DIGESTION

These questions are about your STOMACH AND DIGESTION symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your belly/tummy pain at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was the bloating of your belly/tummy area at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your nausea (urge to vomit) at its worst.

***Response scale removed***

In the last 7 days, how severe was your indigestion and/or heartburn at its worst.

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

Please go to the next page
In the last 7 days, have you been worried about your **unplanned weight loss**?

☐ 0 - No
☐ 1 - Yes

In the last 7 days, have you been worried about your **unplanned weight gain**?

☐ 0 - No
☐ 1 - Yes

In the last 7 days, how severe was your **diarrhoea** at its worst?

*** Response scale removed ***

In the last 7 days, how severe was your **constipation (bowel movements happen less often than normal)** at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

---

Stomach & Digestion Scale Raw Score:
MUSCLES AND JOINTS

These questions are about your MUSCLE AND JOINT symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your muscle pain at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your muscle weakness at its worst?

***Response scale removed***

In the last 7 days, how severe was your muscle stiffness at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your joint pain at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your joint swelling at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe
In the last 7 days, how severe was your **joint stiffness** at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your **muscle twitching** at its worst?

***Response scale removed***

In the last 7 days, how severe was your **muscle cramping** at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was the **tingling and numbness (pins and needles) in your arms and legs** at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

---

**Muscle & Joints Scale Raw Score:** [ ]
MENTAL HEALTH AND WELLBEING

These questions are about your MENTAL HEALTH AND WELLBEING symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your lack of interest in things around you at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your anxiety at its worst?

***Response scale removed***

In the last 7 days, how severe were your feelings of sadness and being miserable at their worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, did you have thoughts about harming yourself in any way?*

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, how severe were your mood swings at their worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

Please go to the next page
In the last 7 days, how severe was your change in appetite at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how often did you feel lonely or unsupported?

***Response scale removed***

In the last 7 days, how often did you feel hopeful about the future?*

- 0 - Never
- 1 - Rarely
- 2 - Sometimes
- 3 - Always

In the last 7 days, did you feel like the person you were before having COVID-19?**

- 0 - No
- 1 - Yes
- Not applicable

**Option for use in research studies involving control groups. Please see the SBQ™-LC user manual for further information.

---

Mental Health & Wellbeing Scale Raw Score: [ ]
SKIN AND HAIR

These questions are about your SKIN AND HAIR symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your dry skin at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your scaly skin at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your itchy skin at its worst?

***Response scale removed***

In the last 7 days, did you have purple-red spots on your feet?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, did you have a rash?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, did you have hives (welts or raised itchy patches of skin)?

- [ ] 0 - No
- [ ] 1 - Yes

Please go to the next page
In the last 7 days, how severe was your hair loss at its worst?

***Response scale removed***

In the last 7 days, how severe were the changes to your nails (ridging, pitting, discolouration, or brittle nails) at their worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

Skin & Hair Scale Raw Score:
EYES

These questions are about your EYE symptoms. Please answer ALL the questions, thinking about your symptoms over the last 7 days.

In the last 7 days, did you have red or bloodshot eyes?

- 0 - No
- 1 - Yes

In the last 7 days, did you have dry eyes?

- 0 – No
- 1 – Yes

In the last 7 days, did you have itchy eyes?

- 0 - No
- 1 - Yes

In the last 7 days, how severe was your blurred vision and/or double vision (not related to wearing glasses) at its worst?

***Response scale removed***

In the last 7 days, how often did you have flashing lights and/or floaters (small dark shapes that float across your vision)?

- 0 - Never
- 1 - Rarely
- 2 - Sometimes
- 3 - Always

In the last 7 days, how severe was your sensitivity to light at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

Please go to the next page
In last 7 days, did you have **watery eyes (excessive tears)**?

- 0 - No
- 1 - Yes

In the last 7 days, did you have a **feeling of pressure behind your eyes**?

- 0 - No
- 1 - Yes

In the last 7 days, how severe was the **feeling of pain behind your eyes** at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how often did you have a **feeling of something rubbing against your eye when you blink (foreign body sensation)**?

- 0 - Never
- 1 - Rarely
- 2 - Sometimes
- 3 - Always

---

**Eyes Scale Raw Score:**
FEMALE REPRODUCTIVE AND SEXUAL HEALTH

These questions are about your FEMALE REPRODUCTIVE AND SEXUAL HEALTH symptoms. Please answer ALL the questions thinking about your symptoms over the last 7 days.

In the last month, did you have unusual changes to your menstrual period (irregular, missed or unexpected period)?

☐ 0 - No  
☐ 1 - Yes  
☐ Not applicable

In the last month, was your premenstrual syndrome (PMS) worse than usual?

☐ 0 - No  
☐ 1 - Yes  
☐ Not applicable

In the last month, did you pass blood clots during your period more than usual?

☐ 0 - No  
☐ 1 - Yes  
☐ Not applicable

In the last 7 days, how severe was your vaginal dryness at its worst?

***Response scale removed***

In the last 7 days, how severe was your vaginal discharge at its worst?

☐ 0 - None  
☐ 1 - Mild  
☐ 2 - Moderate  
☐ 3 - Severe

Please go to the next page
In the last 7 days, were you worried about your ability to have an orgasm or climax?

☐ 0 - No
☐ 1 - Yes
☐ Not applicable

In the last 7 days, how severe was your decreased interest in sex at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

Female Reproductive & Sexual Health Scale Raw Score:
MALE REPRODUCTIVE AND SEXUAL HEALTH

These questions are about your MALE REPRODUCTIVE AND SEXUAL HEALTH symptoms. Please answer ALL the questions thinking about your symptoms over the last 7 days.

In the last 7 days, how severe was your difficulty getting or keeping an erection at its worst?

- □ 0 - None
- □ 1 - Mild
- □ 2 - Moderate
- □ 3 - Severe

In the last 7 days, did you have difficulty with ejaculation?

***Response to reviewers***

In the last 7 days, did you have a decreased interest in sex?

- □ 0 - No
- □ 1 - Yes

Male Reproductive & Sexual Health Scale Raw Score:
OTHER SYMPTOMS

These questions are about your OTHER SYMPTOMS. Please answer ALL the questions thinking about your symptoms over the last 7 days.

In the last 7 days, did you have a fever?

☐ 0 - No
☐ 1 - Yes

In the last 7 days, how often did you have chills/shivering?

***Response to reviewers***

In the last 7 days, how severe was your sweating problem at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

In the last 7 days, how severe were your hot flushes at their worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

In the last 7 days, how severe was your aching all over the body at its worst?

☐ 0 - None
☐ 1 - Mild
☐ 2 - Moderate
☐ 3 - Severe

Please go to the next page
In the last 7 days, how severe was the **swelling of your glands (lymph nodes)** at its worst?

- [ ] 0 - None
- [ ] 1 - Mild
- [ ] 2 - Moderate
- [ ] 3 - Severe

In the last 7 days, how severe was your **vertigo (when everything around you was spinning enough to affect your balance)** at its worst?

***Response scale removed***

In the last 7 days, did you have **swelling of your face, lips, tongue, and/or throat**?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, did you experience a **heightened reaction to known allergies**?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, did you experience a **heightened reaction to new allergies**?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, did you have **loss of control of urine (leakage)**?

- [ ] 0 - No
- [ ] 1 - Yes

In the last 7 days, did you have **difficulty passing urine**?

- [ ] 0 - No
- [ ] 1 - Yes

Please go to the next page
In the last 7 days, have you been passing more urine than usual?

- 0 - No
- 1 - Yes

In the last 7 days, how severe was your increased thirst at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe were your mouth ulcers at their worst?

***Response scale has been removed***

In the last 7 days, did you experience a worsening of known dental problems?

- 0 - No
- 1 - Yes

In the last 7 days, how severe was your dry mouth at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

In the last 7 days, how severe was your headache at its worst?

- 0 - None
- 1 - Mild
- 2 - Moderate
- 3 - Severe

Other Symptoms Scale Raw Score:
IMPACT ON DAILY LIFE

For EACH question, please select one answer that best describes how your symptoms have affected you in the last 7 days. Please answer ALL the questions.

In the last 7 days, have your symptoms affected your ability to work, volunteer, go to school or take part in organised activities?

- 0 - Not at all
- 1 - Very little
- 2 - Somewhat
- 3 - Severely

In the last 7 days, have your symptoms affected your ability to go shopping?

***Response to reviewers***

In the last 7 days, have your symptoms affected your ability to do housework or light chores?

- 0 - Not at all
- 1 - Very little
- 2 - Somewhat
- 3 - Severely

In the last 7 days, have your symptoms affected your ability to move around easily?

- 0 - Not at all
- 1 - Very little
- 2 - Somewhat
- 3 - Severely

Please go to the next page
In the last 7 days, have your symptoms affected your ability to look after yourself (bathing and dressing)?

☐ 0 - Not at all
☐ 1 - Very little
☐ 2 - Somewhat
☐ 3 - Severely

In the last 7 days, have your symptoms affected your relationships with others (friends and family)?

***Response to reviewers***

In the last 7 days, have your symptoms affected your ability to socialise and interact with others?

☐ 0 - Not at all
☐ 1 - Very little
☐ 2 - Somewhat
☐ 3 - Severely

In the last 7 days, have your symptoms affected your ability to enjoy life?

☐ 0 - Not at all
☐ 1 - Very little
☐ 2 - Somewhat
☐ 3 - Severely

---

**Impact on Daily Life Scale Raw Score:**

---
Do you have any other symptoms you wish to report?

☐ 0 - No
☐ 1 - Yes

If **YES**, which other symptom(s) do you wish to report?

<table>
<thead>
<tr>
<th>Symptom (please describe each symptom on a new row):</th>
<th>In the last 7 days, what was the severity of this symptom at its worst?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example: bruising</td>
<td>☐ 1 - Mild  ☑ 2 - Moderate  ☐ 3 - Severe</td>
</tr>
<tr>
<td></td>
<td>☐ 1 - Mild  ☐ 2 - Moderate  ☑ 3 - Severe</td>
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<tr>
<td></td>
<td>☐ 1 - Mild  ☑ 2 - Moderate  ☑ 3 - Severe</td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this questionnaire.
To convert the raw scores for each scale to 0-100 linear scores, please use the conversion tables found in the appendix of the SBQ™-LC User Manual. Higher scores indicate greater symptom burden.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Scale Raw Score</th>
<th>0-100 Converted Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td></td>
<td></td>
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<tr>
<td>Pain</td>
<td></td>
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<tr>
<td>Circulation</td>
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<tr>
<td>Fatigue</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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Symptom Burden Questionnaire™ for Long COVID (SBQ™-LC)
Profile

0-100 Scale Score

Breathing  |  Pain  |  Circulation  |  Fatigue  |  Movement  |  Sleep  |  Ears, Nose & Throat  |  Stomach & Digestion  |  Muscles & Joints  |  Mental Health & Wellbeing  |  Sexual & Reproductive Health  |  Other Symptoms  |  Impact on Daily Life