

# Participant Information

Please complete the survey below.

Thank you!

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Participant Study ID

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Today's Date

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Participant Full Name

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(Please type your first and last name)

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Date of Birth

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(Click on the calendar logo to select a date)

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Height (in)

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Weight (lbs)

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BMI

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Did you experience any symptoms due to COVID-19?

- Yes  
 No - I was asymptomatic

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What day did these symptoms begin?

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(Give your closest approximation)

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What was the date of your positive test? If you tested positive multiple times, please select the date of your earliest positive test.

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Are you still experiencing symptoms due to COVID-19?

Yes  
No

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How long did it take for symptoms from this illness episode to subside?

- 3 days  
 5 days  
 7 days  
 10 days  
 2 weeks  
 3 weeks  
 4 weeks or more  
(Provide your closest approximation)

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Which symptoms have you continued to experience?  
Please select all that apply

Feeling feverish  
Cough  
Chills or shivering  
Sweats  
Sore throat or itchy/scratchy throat  
Nausea or vomiting  
Runny or stuffy nose  
Muscle or body aches  
Increased trouble breathing  
Fatigue  
Diarrhea  
Rash  
Ear pain or ear discharge  
Loss of sense of taste  
Loss of sense of smell  
Headache  
Chest pain  
Joint pain  
Dry eyes and mouth  
Vertigo  
Lack of appetite  
Lowering of vision  
Fainting  
Nerve pain  
Other

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Please describe what other symptom(s) you are currently experiencing due to COVID-19.

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Did you access any of the following types of care after your COVID-19 symptoms resolved?

- Drive-through testing only
- Saw primary care doctor / nurse practitioner / physician assistant
- Urgent Care
- Emergency room
- Admitted to hospital
- Admitted to ICU
- None of the above
- Do not know
- Prefer not to say

# Questionnaire

Please complete the survey below.

Thank you!

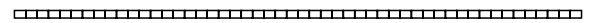
In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your illness onset on [symptom\_onset], compared to your ability to perform these activities today.

In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your diagnosis on [test\_date], compared to your ability to perform these activities today.

How do you rate your health before you had COVID-19?

Worst imaginable  
health

Best imaginable  
health

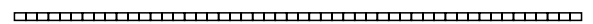


(Place a mark on the scale above)

How do you rate your health today?

Worst imaginable  
health

Best imaginable  
health



(Place a mark on the scale above)

## Climbing stairs and transferring

**This includes any of the following: getting into/out of bed, standing up/sitting down in a chair, getting into/out of a car, getting on/off a toilet, stepping onto a curb.**

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need climbing stairs/transferring?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TODAY, how much help do you need climbing stairs/transferring?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

## Personal grooming and dressing

**This includes any of the following: brushing/flossing teeth, denture care, skin care, shaving, putting on socks and shoes, taking off underwear, putting on pants, putting on a jacket.**

None, I can perform these tasks independently

A little help

A lot of help

Unable to perform task

BEFORE you were diagnosed with COVID-19, how much help did you need with personal grooming and dressing?

TODAY, how much help do you need with personal grooming and dressing?

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

### Using the toilet and bathing

**This includes any of the following: wiping your body with wipes, taking a shower or bath, scrubbing and rinsing your body, wiping after you use the toilet.**

None, I can perform these tasks independently

A little help

A lot of help

Unable to perform task

BEFORE you were diagnosed with COVID-19, how much help did you need using the restroom and bathing?

TODAY, how much help do you need using the restroom and bathing?

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

### Doing household chores

**This includes any of the following: food preparation, cooking, folding laundry, vacuuming the floor, making the bed, feeding pets, wiping a table, loading the dishwasher, tidying up a room.**

None, I can perform these tasks independently

A little help

A lot of help

Unable to perform task

BEFORE you were diagnosed with COVID-19, how much help did you need doing household chores?

TODAY, how much help do you need doing household chores?

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

### Managing personal affairs

**This includes any of the following: using the phone or computer, paying bills, scheduling a doctor appointment, managing medications, refilling a prescription, making a shopping list**

None, I can perform these tasks independently

A little help

A lot of help

Unable to perform task

BEFORE you were diagnosed with COVID-19, how much help did you need managing your personal affairs?

TODAY, how much help do you need managing your personal affairs?

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

Do you experience shortness of breath or fatigue when performing any activities in the following categories? Please select all that apply.

- Climbing stairs or transferring
- Personal grooming and dressing
- Using the toilet and bathing
- Doing household chores
- Managing personal affairs

When you are climbing stairs or transferring, how often do you feel shortness of breath/fatigue?

- 0-25% of the time
- 25-50% of the time
- 50-75% of the time
- 75-100% of the time

When you are dressing or performing personal grooming, how often do you feel shortness of breath/fatigue?

- 0-25% of the time
- 25-50% of the time
- 50-75% of the time
- 75-100% of the time

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When you are using the toilet or bathing, how often do you feel shortness of breath/fatigue?

- 0-25% of the time
- 25-50% of the time
- 50-75% of the time
- 75-100% of the time

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When you are doing household chores, how often do you feel shortness of breath/fatigue?

- 0-25% of the time
- 25-50% of the time
- 50-75% of the time
- 75-100% of the time

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When you are managing your personal affairs, how often do you feel shortness of breath/fatigue?

- 0-25% of the time
- 25-50% of the time
- 50-75% of the time
- 75-100% of the time

# Lingering Symptoms

Please complete the survey below.

Thank you!

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Today's Date

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Participant Full Name

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(Please type your first and last name)

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Are you still experiencing symptoms due to COVID-19?

- Yes  
 No

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Which symptoms have you continued to experience?  
Please select all that apply

- Feeling feverish  
 Cough  
 Chills or shivering  
 Sweats  
 Sore throat or itchy/scratchy throat  
 Nausea or vomiting  
 Runny or stuffy nose  
 Muscle or body aches  
 Increased trouble breathing  
 Fatigue  
 Diarrhea  
 Rash  
 Ear pain or ear discharge  
 Loss of sense of taste  
 Loss of sense of smell  
 Headache  
 Chest pain  
 Joint pain  
 Dry eyes and mouth  
 Vertigo  
 Lack of appetite  
 Lowering of vision  
 Fainting  
 Nerve pain  
 Other

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Please describe what other symptom(s) you are currently experiencing due to COVID-19.

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Have you accessed any of the following types of care after your previous HAARVI appointment, related to lingering COVID-19 symptoms?

- Drive-through testing only  
 Saw primary care doctor / nurse practitioner / physician assistant  
 Urgent Care  
 Emergency room  
 Admitted to hospital  
 Admitted to ICU  
 None of the above  
 Do not know  
 Prefer not to say

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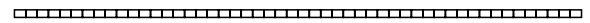
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In this survey, we are going to ask you some questions about your ability to perform certain activities before and after you were diagnosed with COVID-19. Please think about your ability to perform these activities 30 days prior to your diagnosis on [test\_date], compared to your ability to perform these activities today.

How do you rate your health before you had COVID-19?

Worst imaginable  
health

Best imaginable  
health

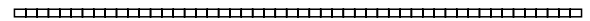


(Place a mark on the scale above)

How do you rate your health today?

Worst imaginable  
health

Best imaginable  
health



(Place a mark on the scale above)

### Climbing stairs and transferring

**This includes any of the following: getting into/out of bed, standing up/sitting down in a chair, getting into/out of a car, getting on/off a toilet, stepping onto a curb.**

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need climbing stairs/transferring?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TODAY, how much help do you need climbing stairs/transferring?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

### Personal grooming and dressing

**This includes any of the following: brushing/flossing teeth, denture care, skin care, shaving, putting on socks and shoes, taking off underwear, putting on pants, putting on a jacket.**

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need with personal grooming and dressing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



TODAY, how much help do you need with personal grooming and dressing?

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed.)

### Using the toilet and bathing

**This includes any of the following: wiping your body with wipes, taking a shower or bath, scrubbing and rinsing your body, wiping after you use the toilet.**

	None, I can perform these tasks independently	A little help	A lot of help	Unable to perform task
BEFORE you were diagnosed with COVID-19, how much help did you need using the restroom and bathing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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### Managing personal affairs

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BEFORE you were diagnosed with COVID-19, how much help did you need managing your personal affairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TODAY, how much help do you need managing your personal affairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please state which activities, if any, have been impacted and describe how they have been impacted.

(Ex: Prior to my illness, I would need to sit for a moment before rising out of bed independently. Now I require another person's help to get out of bed. )

Do you experience shortness of breath or fatigue when performing any activities in the following categories? Please select all that apply.

- Climbing stairs or transferring
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- Using the toilet and bathing
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- Managing personal affairs

When you are climbing stairs or transferring, how often do you feel shortness of breath/fatigue?

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When you are managing your personal affairs, how often do you feel shortness of breath/fatigue?

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