Covid-19 History

Have you had corona virus 2019 (COVID-19)?	◯ I had a confirmed case of COVID-19. ◯ I had a suspected/possible case of COVID-19. ◯ I had more than one confirmed and/or possible case of COVID-19. ◯ I do not think that I have had a case of COVID-19.
How many confirmed cases of COVID-19 have you had?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ >4
How was your first diagnosis confirmed?	◯ PCR test ◯ Antigen test (quick test) ◯ Other ◯ I am not sure
When was your first diagnosis confirmed?	_____ (Please provide approximate date if unsure.)
When you were ill with your first possible/confirmed COVID-19, which did you experience? Please check all that apply	☐ Cough ☐ Fever ☐ Shortness of breath or difficulty breathing ☐ Headache ☐ Muscle ache ☐ New loss of smell or taste ☐ Chest pain or tightness in chest ☐ Chills ☐ Excessive fatigue ☐ Nausea/vomiting ☐ Diarrhea ☐ Abdominal pain ☐ Skin rash ☐ Conjunctivitis ☐ Nasal congestion ☐ Sore throat
Please describe the severity of fatigue that you experienced.	◯ Mild - I could perform daily activities with some difficulty. ◯ Significant - I had significant difficulty performing daily activities. ◯ Severe - I struggled to even get out of bed.
Please describe the severity of the shortness of breath that you experienced.	◯ Mild - slight shortness of breath during ordinary activity ◯ Significant - breathing was comfortable only at rest ◯ Severe - breathing was difficult even at rest
Did you have any other symptoms not listed above?	◯ Yes ◯ No
Please describe these symptoms.	_____

Were you hospitalized for your symptoms?
◯ Yes ◯ No

What treatments did you receive while in the hospital?
☐ None
☐ Oxygen and fluids: Breathing support administered through an oxygen mask, no pressure applied
☐ Non-invasive ventilation: Breathing support administered through an oxygen mask, which pushes oxygen into your lungs
☐ Invasive ventilation: Breathing support administered through an inserted tube. People are usually asleep for this procedure
☐ Other

How was your second diagnosis confirmed?
◯ PCR test
◯ Antigen test (quick test)
◯ Other
◯ I am not sure

When was your second diagnosis confirmed?
_____
(Please provide approximate date if unsure.)

When you were ill with your second possible/confirmed COVID-19, which did you experience? Please check all that apply
☐ Cough
☐ Fever
☐ Shortness of breath or difficulty breathing
☐ Headache
☐ Muscle ache
☐ New loss of smell or taste
☐ Chest pain or tightness in chest
☐ Chills
☐ Excessive fatigue
☐ Nausea/vomiting
☐ Diarrhea
☐ Abdominal pain
☐ Skin rash
☐ Conjunctivitis
☐ Nasal congestion
☐ Sore throat

Please describe the severity of fatigue that you experienced.
◯ Mild - I could perform daily activities with some difficulty.
◯ Significant - I had significant difficulty performing daily activities.
◯ Severe - I struggled to even get out of bed.

Please describe the severity of the shortness of breath that you experienced.
◯ Mild - slight shortness of breath during ordinary activity
◯ Significant - breathing was comfortable only at rest
◯ Severe - breathing was difficult even at rest

Did you have any other symptoms not listed above?
◯ Yes
◯ No

Please describe these symptoms.
_____

Were you hospitalized for your symptoms?
◯ Yes ◯ No

What treatments did you receive while in the hospital?

- ☐ None
- ☐ Oxygen and fluids: Breathing support administered through an oxygen mask, no pressure applied
- ☐ Non-invasive ventilation: Breathing support administered through an oxygen mask, which pushes oxygen into your lungs
- ☐ Invasive ventilation: Breathing support administered through an inserted tube. People are usually asleep for this procedure
- ☐ Other

How was your third diagnosis confirmed?

- ◯ PCR test
- ◯ Antigen test (quick test)
- ◯ Other
- ◯ I am not sure

When was your third diagnosis confirmed?

_____

(Please provide approximate date if unsure.)

When you were ill with your third possible/confirmed COVID-19, which did you experience? Please check all that apply

- ☐ Cough
- ☐ Fever
- ☐ Shortness of breath or difficulty breathing
- ☐ Headache
- ☐ Muscle ache
- ☐ New loss of smell or taste
- ☐ Chest pain or tightness in chest
- ☐ Chills
- ☐ Excessive fatigue
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Skin rash
- ☐ Conjunctivitis
- ☐ Nasal congestion
- ☐ Sore throat

Please describe the severity of fatigue that you experienced.

- ◯ Mild - I could perform daily activities with some difficulty.
- ◯ Significant - I had significant difficulty performing daily activities.
- ◯ Severe - I struggled to even get out of bed.

Please describe the severity of the shortness of breath that you experienced.

- ◯ Mild - slight shortness of breath during ordinary activity
- ◯ Significant - breathing was comfortable only at rest
- ◯ Severe - breathing was difficult even at rest

Did you have any other symptoms not listed above?

- ◯ Yes
- ◯ No

Please describe these symptoms.

_____

Were you hospitalized for your symptoms?

◯ Yes ◯ No

What treatments did you receive while in the hospital?

- ☐ None
- ☐ Oxygen and fluids: Breathing support administered through an oxygen mask, no pressure applied
- ☐ Non-invasive ventilation: Breathing support administered through an oxygen mask, which pushes oxygen into your lungs
- ☐ Invasive ventilation: Breathing support administered through an inserted tube. People are usually asleep for this procedure
- ☐ Other

How was your most recent diagnosis confirmed?

- ◯ PCR test
- ◯ Antigen test (quick test)
- ◯ Other
- ◯ I am not sure

When was your most recent diagnosis confirmed?

_____
(Please provide approximate date if unsure.)

Why do you think you may have had COVID-19?

_____

When did your possible COVID-19 symptoms start?

_____
(Please provide approximate date if unsure.)

When you were ill with the most recent possible/confirmed COVID-19, which did you experience? Please check all that apply

- ☐ Cough
- ☐ Fever
- ☐ Shortness of breath or difficulty breathing
- ☐ Headache
- ☐ Muscle ache
- ☐ New loss of smell or taste
- ☐ Chest pain or tightness in chest
- ☐ Chills
- ☐ Excessive fatigue
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Skin rash
- ☐ Conjunctivitis
- ☐ Nasal congestion
- ☐ Sore throat

Please describe the severity of fatigue that you experienced.

- ◯ Mild - I could perform daily activities with some difficulty.
- ◯ Significant - I had significant difficulty performing daily activities.
- ◯ Severe - I struggled to even get out of bed.

Please describe the severity of the shortness of breath that you experienced.

- ◯ Mild - slight shortness of breath during ordinary activity
- ◯ Significant - breathing was comfortable only at rest
- ◯ Severe - breathing was difficult even at rest

Did you have any other symptoms not listed above?

- ◯ Yes
- ◯ No

Please describe these symptoms.	_____
Were you hospitalized for your symptoms?	◯ Yes ◯ No
What treatments did you receive while in the hospital?	☐ None ☐ Oxygen and fluids: Breathing support administered through an oxygen mask, no pressure applied ☐ Non-invasive ventilation: Breathing support administered through an oxygen mask, which pushes oxygen into your lungs ☐ Invasive ventilation: Breathing support administered through an inserted tube. People are usually asleep for this procedure ☐ Other
How do you feel right now?	◯ I feel as healthy as normal. ◯ I'm not feeling quite right.
If you are able to measure it, what is your temperature?	_____
Have you received at least one dose/shot of a COVID-19 vaccine?	◯ -No ◯ -Yes, Pfizer-BioNtech ◯ -Yes, Moderna ◯ -Yes, Johnson & Johnson ◯ -Yes, Oxford-AstraZeneca ◯ -Yes, another COVID-19 vaccine ◯ -Yes, but I don't know which COVID-19 vaccine
Please specify what COVID-19 vaccine you received.	_____
If Yes - How many days ago did you receive your first vaccine dose?	◯ 1-14 days ◯ 15-21 days ◯ 22-28 days ◯ 28+ days
When did you receive your first vaccine dose?	_____ (Please provide approximate date if unsure.)
When did you receive your last vaccine dose?	_____ (Please provide approximate date if unsure.)
Did you receive a booster shot?	◯ Yes ◯ No
How many booster shot(s) have you received?	◯ 1 ◯ 2

Which booster shot did you receive?

- ◯ Pfizer-BioNtech
- ◯ Moderna
- ◯ Johnson & Johnson
- ◯ Oxford-AstraZeneca
- ◯ Another COVID-19 vaccine
- ◯ I don't know which COVID-19 vaccine

Please specify what booster shot you received.

_____

When did you receive your first booster shot?

_____
(Please provide approximate date if unsure.)

Which booster shot did you receive the second time?

- ◯ Pfizer-BioNtech
- ◯ Moderna
- ◯ Johnson & Johnson
- ◯ Oxford-AstraZeneca
- ◯ Another COVID-19 vaccine
- ◯ I don't know which COVID-19 vaccine

Please specify what booster shot you received.

_____

When did you receive your second booster shot?

_____
(Please provide approximate date if unsure.)

Are you currently still experiencing smell and/or taste loss?

- ◯ Yes
- ◯ No

Are you currently experiencing any distorted sense of smell?

- ◯ Yes, I smell things that were not what they used to smell like (Parosmia).
- ◯ Yes, I smell things that were not there, i.e. clean air (Phantomsmia).
- ◯ Yes, I experience both (Parosmia and Phantomia).
- ◯ No, I don't experience distorted sense of smell. I only experience diminished sense of smell.

Do you experience distorted smell all the time or just some of the time?

- ◯ once every day
- ◯ twice every day
- ◯ 3-5 times every day
- ◯ 5-10 times every day
- ◯ 10-20 time every day
- ◯ I experience it all the time

Please rate the severity of your smell distortion:

Extremely unpleasant	Neutral (doesn't bother me much)	Extremely pleasant (I like it)

(Place a mark on the scale above)

Do certain smells trigger it? If so, please describe them.

_____

When did you notice the distorted sense of smell? e.g. how many days after your COVID-19 diagnosis?

_____

Has it changed since you first noticed it?	◯ Worsened ◯ Improved ◯ No change
Does the altered smell occur in one or both nostrils?	◯ Right side ◯ Left side ◯ both sides

Please rate the following statements on a scale of "Strongly disagree" (no impact on quality of life) to "Strongly agree" (severe impact on quality of life)

1. Changes in my sense of smell isolate me socially.	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree
2. The problems with my sense of smell have a negative impact on my daily social activities.	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree
3. The problems with my sense of smell make me more irritable.	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree
4. Because of the problems with my sense of smell, I eat out less.	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree
5. Because of the problems with my sense of smell, I eat less than before (loss of appetite).	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree
6. Because of the problems with my sense of smell, I have to make more effort to relax.	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree

7. I'm afraid I'll never be able to get used to the problems with my sense of smell.	◯ Strongly disagree ◯ Disagree ◯ Slightly disagree ◯ Neither agree nor disagree ◯ Slightly agree ◯ Agree ◯ Strongly agree
Since having COVID-19, the amount of food that I typically eat has	◯ stayed about the same ◯ decreased ◯ increased
Since having COVID-19, the types or varieties of foods that I eat have	◯ stayed about the same ◯ decreased ◯ increased
Since having COVID-19, my enjoyment of eating has	◯ stayed about the same ◯ decreased ◯ increased
Since having COVID-19, my weight has	◯ stayed about the same ◯ decreased ◯ increased

Feel free to provide any other comments here.

_____