**COVID RELATED QUESTIONS AT BASELINE**

**1a. Have you received the COVID vaccine?**

[ ]  Yes [ ]  No

**1b. If yes:**

Date of first dose (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_ Type/manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of second dose (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_ Type/manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of third dose (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_ Type/manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of fourth dose (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_ Type/manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of fifth dose (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_ Type/manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How are you feeling today? 0 no symptoms/ 1 Mild / 2 Moderate/ 3 Severe/ 4 Very severe

3. Please rate interference in daily activities due to illness: 1 Not at all/ 2 A little bit/ 3 Somewhat/ 4 Quite a bit/ 5 Very much

4. How is your general health? 1 Poor/ 2 Fair/ 3 Good / 4 Very good/ 5 Excellent

Please rate the following symptoms:

5. Fever: No problem / Mild problem / Moderate problem / Major problem

6. Cough: No problem / Mild problem / Moderate problem / Major problem

7. Shortness of breath: No problem / Mild problem / Moderate problem / Major problem

8. Loss of taste/ smell: No problem / Mild problem / Moderate problem / Major problem

9. Muscle ache: No problem / Mild problem / Moderate problem / Major problem

10. Nausea / vomiting: No problem / Mild problem / Moderate problem / Major problem

11. Fatigue: No problem / Mild problem / Moderate problem / Major problem

12. Difficult concentrating: No problem / Mild problem / Moderate problem / Major problem

13. Anxious mood No problem / Mild problem / Moderate problem / Major problem

**3. EQ-5D-5L**

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**Under each heading, please tick the ONE box that best describes your health TODAY.**

|  |  |
| --- | --- |
| **MOBILITY** |  |
| I have no problems in walking about | **** |
| I have slight problems in walking about | **** |
| I have moderate problems in walking about | **** |
| I have severe problems in walking about | **** |
| I am unable to walk about | **** |
|  |  |
| **SELF-CARE** |  |
| I have no problems washing or dressing myself | **** |
| I have slight problems washing or dressing myself | **** |
| I have moderate problems washing or dressing myself | **** |
| I have severe problems washing or dressing myself | **** |
| I am unable to wash or dress myself | **** |
|  |  |
| **USUAL ACTIVITIES** *(e.g., work, study, housework, family or leisure activities)* |  |
| I have no problems doing my usual activities | **** |
| I have slight problems doing my usual activities | **** |
| I have moderate problems doing my usual activities | **** |
| I have severe problems doing my usual activities | **** |
| I am unable to do my usual activities | **** |
|  |  |
| **PAIN / DISCOMFORT** |  |
| I have no pain or discomfort | **** |
| I have slight pain or discomfort | **** |
| I have moderate pain or discomfort | **** |
| I have severe pain or discomfort | **** |
| I have extreme pain or discomfort | **** |
|  |  |
| **ANXIETY / DEPRESSION** |  |
| I am not anxious or depressed | **** |
| I am slightly anxious or depressed | **** |
| I am moderately anxious or depressed | **** |
| I am severely anxious or depressed | **** |
| I am extremely anxious or depressed | **** |

* We would like to know how good or bad your health is TODAY.

The best health

you can imagine

* This scale is numbered from 0 to 100.
* 100 means the best health you can imagine.
0 means the worst health you can imagine.
* Please mark an X on the scale to indicate how your health is TODAY.
* Now, write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

Measurements

|  |  |
| --- | --- |
| Weight (kg) |  |
| Height (cm) |  |
| BMI |  |