**Follow-Up Data Collection: 28-days**

 **1. COVID QUESTIONS**

**1. Do you feel recovered today (i.e., symptoms associated with illness are no longer a problem)?**

[ ]  Yes [ ]  No

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

5. Have you returned to your usual health today?

\_\_\_\_ YES

\_\_\_\_ No

6. Have you returned to your usual activities today?

\_\_\_\_ YES

\_\_\_\_ NO

As you do not feel recovered, please rate the following symptoms:

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

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

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

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

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

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

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

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

15. Anxious mood: No problem / Mild problem / Moderate problem / Major problem

**Healthcare services**

**16a. Have you had any out-patient visit since you completed the last survey?**

[ ]  Yes [ ]  No

**16b. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**17a. Have you had any emergency department visit since you completed the last survey?**

[ ]  Yes [ ]  No

**17b. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**18a. Have you had any hospitalization since you completed the last survey?**

[ ]  Yes [ ]  No

**18b. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**19a. Did you complete your course of medication as prescribed by the study doctor?**

[ ]  Yes [ ]  No

[ ]  Not applicable (Standard of care)

**19b. If you discontinued your medication early, when did you do so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

6. Have you received any additional COVID-19 vaccinations since the last survey?[ ]  Yes [ ]  No

**6a. If yes, Date of vaccination:**

**6b. Type/ Manufacturer:**

**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 =

The best health

you can imagine