**Follow-Up Data Collection: 36-weeks**

**1. COVID QUESTIONS**

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

Yes  No

**2a. Have you had any out-patient visit since you completed the Day 90 survey?**

Yes  No

**2b. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3a. Have you had any emergency department visit since you completed the Day 90 survey?**

Yes  No

**3b. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4a. Have you had any hospitalization since you completed the last survey?**

Yes  No

**4b. If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4c.**

|  |  |  |
| --- | --- | --- |
| **Admission Date** | **Discharge Date** | **Reason for Admission** |
| DD-MMM-YYYY | DD-MMM-YYYY  Ongoing | Hospitalization due to the progression of COVID-19 (defined as worsening of viral pneumonia) or complications related to COVID-19  Hospitalization for any other cause, specify: \_\_\_\_\_\_\_ |
| DD-MMM-YYYY | DD-MMM-YYYY  Ongoing | Hospitalization due to the progression of COVID-19 (defined as worsening of viral pneumonia) or complications related to COVID-19  Hospitalization for any other cause, specify: \_\_\_\_\_\_\_ |
| Add columns as needed. |  |  |

5. Have you received any additional COVID-19 vaccinations since the last survey?

Yes  No

**5a. If yes, Date of vaccination:**

**5b. Type/ Manufacturer:**

**2. LONG COVID**

**1. The World Health Organization defines long-COVID as the following, “*Post COVID-19 condition occurs in individuals with a history of probable or confirmed SARS CoV-2 infection, usually 3 months from the onset of COVID-19 with symptoms and that last for at least 2 months and cannot be explained by an alternative diagnosis. Common symptoms include fatigue, shortness of breath, cognitive dysfunction but also others and generally have an impact on everyday functioning. Symptoms may be new onset following initial recovery from an acute COVID-19 episode or persist from the initial illness. Symptoms may also fluctuate or relapse over time.*”** **Does this definition apply to you?**

Yes  No

**3. SYMPTOM BURDEN QUESTIONNAIRE**

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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?

0 – None

1 – Mild

2 – Moderate  3 – Severe

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

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?

0 – None

1 – Mild

2 – Moderate  3 – Severe

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

0 – None

1 – Mild

2 – Moderate  3 – Severe

**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?

0 – None

1 – Mild

2 – Moderate  3 – Severe

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

0 – None

1 – Mild

2 – Moderate  3 – Severe

**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?

0 – None

1 – Mild

2 – Moderate  3 – Severe

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

0 – None

1 – Mild

2 – Moderate  3 – Severe

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

0 – No

1 – Yes

**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 1 - Yest 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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

**MEMORY, THANKING AND COMMUNICATION**

These questions are about your MEMORY, THINKING, AND COMMUNCATION 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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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 (1 - Yest related to dyslexia)**?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

**MOVEMENT**

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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

**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**?

☐ 0 – Never

☐ 1 – Rarely

☐ 2 – Sometimes ☐ 3 – Always

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

**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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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 – Yes

☐ 1 – No

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

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

In the last 7 days, did you have ***new* hearing loss**?

☐ 0 – Yes

☐ 1 – No

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

at its worst?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

**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.

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – None

☐ 1 – Mild

☐ 2 - Moderate ☐ 3 – Severe

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

**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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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?

☐ 0 – None

☐ 1 – Mild

☐ 2 - Moderate ☐ 3 – Severe

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

**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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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**?

☐ 0 – Never

☐ 1 – Rarely

☐ 2 – Sometimes ☐ 3 – Always

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 – Yes

☐ 1 – No

**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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

**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 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

In last 7 days, did you have **watery eyes (excessive tears)**?

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

**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 un**usual changes to your menstrual period (irregular, missed or unexpected period)**?

☐ 0 – Yes

☐ 1 – No

☐ Not applicable

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

☐ 0 – Yes

☐ 1 – No

☐ Not applicable

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

☐ 0 – Yes

☐ 1 – No

☐ Not applicable

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

☐ 0 – None

☐ 1 – Mild

☐ 2 - Moderate ☐ 3 – Severe

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

☐ 0 – None

☐ 1 – Mild

☐ 2 - Moderate ☐ 3 – Severe

In the last 7 days, were you **worried about your ability to have an orgasm or climax**?

☐ 0 – Yes

☐ 1 – No

☐ 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

**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**?

☐ 0 – Yes

☐ 1 – No

☐ Not applicable

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

☐ 0 – Yes

☐ 1 – No

☐ Not applicable

**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 – Yes

☐ 1 – No

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

☐ 0 – Never

☐ 1 – Rarely

☐ 2 – Sometimes ☐ 3 – Always

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

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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

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

☐ 0 – Yes

☐ 1 – No

In the last 7 days, have you been **passing more urine than usual**?

☐ 0 – Yes

☐ 1 – No

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?

☐ 0 – None

☐ 1 – Mild

☐ 2 – Moderate ☐ 3 – Severe

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

☐ 0 – Yes

☐ 1 – No

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

**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.

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**?

☐ 0 – Not at all

☐ 1 – Very little

☐ 2 – Somewhat ☐ 3 – Severely

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

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)**?

☐ 0 – Not at all

☐ 1 – Very little

☐ 2 – Somewhat ☐ 3 – Severely

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

Do you have any other symptoms you wish to report?

☐ 0 – Yes

☐ 1 – No

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

|  |  |  |  |
| --- | --- | --- | --- |
| Symptom (please describe each symptom on a new row): | In the last 7 days, what was the severity of this symptom at its worst? | | |
| For example:  **Bruising** |  |  |  |
| 1 – Mild | 2 – Moderate | 3 – Severe |
|  |  |  |  |
| 1 – Mild | 2 – Moderate | 3 – Severe |
|  |  |  |  |
| 1 – Mild | 2 – Moderate | 3 – Severe |

**4. 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.
* Chart, diagram

  Description automatically generated100 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