## SYMPTOMS OF COVID-19

1. **Have you had any symptoms of COVID-19?** *Common symptoms include fever, cough, and difficulty breathing. Other symptoms include chills, muscle pain, sore throat, headache, and loss of smell or taste.*

   ☐ Yes
   ☐ No

2. **Has a doctor or other health professional told you that you may have had COVID-19?**

   ☐ Yes, definitely
   ☐ Yes, possibly
   ☐ No

3. **Have you had a <u>positive</u> test for COVID-19?**

   ☐ Yes
   ☐ No

4. **If you have had symptoms or a diagnosis or positive test, when your symptoms were at their worst, how bad or bothersome were they?**

   ☐ Mild
   ☐ Moderate
   ☐ Severe
   ☐ Very severe
   ☐ Does not apply (did not have symptoms, diagnosis or positive test)

5. **Did any people living with you have symptoms or a diagnosis or a positive test for COVID-19?** *If you live in an apartment building or assisted, independent or nursing facility, please answer about your own apartment/unit.*

   ☐ Yes
   ☐ No
   ☐ I haven't lived with anyone else during the outbreak

Contains items 5-9 (section "SYMPTOMS OF COVID-19") and was renumbered from the full document "National Health and Aging Trends Study COVID-19 Questionnaire"

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