If yes to Q7:

For participants who have recovered from symptoms related to COVID-19 illness:

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?	**B. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5? (1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = quite a bit, 5 = very much)**	**C. How long, in days, did the symptom last?**
Fever	○ Yes ○ No		
Trouble breathing	○ Yes ○ No		
Chest congestion	○ Yes ○ No		
Chest tightness	○ Yes ○ No		
Dry or hacking cough	○ Yes ○ No		
Wet or loose cough	○ Yes ○ No		
Body aches or pains	○ Yes ○ No		
Chills or shivering	○ Yes ○ No		
Sore or painful throat	○ Yes ○ No		
Congested or stuffy nose	○ Yes ○ No		
Runny or dripping nose	○ Yes ○ No		
Diarrhea	○ Yes ○ No		
Weak or tired	○ Yes ○ No		
Loss of smell	○ Yes ○ No		
Loss of taste	○ Yes ○ No		

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

○ Mild ○ Moderate ○ Severe ○ Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much

Skip to question 9

If no to Q7:

For participants who continue to have symptoms related to COVID-19 illness:

	A. During your COVID-19 illness, did you have worsening of this symptom compared to your usual state of health?	**B. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5? (1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = quite a bit, 5 = very much)**	**C. How long, in days, has this symptom bothered you?**
Fever	○ Yes ○ No		
Trouble breathing	○ Yes ○ No		
Chest congestion	○ Yes ○ No		
Chest tightness	○ Yes ○ No		
Dry or hacking cough	○ Yes ○ No		
Wet or loose cough	○ Yes ○ No		
Body aches or pains	○ Yes ○ No		
Chills or shivering	○ Yes ○ No		
Sore or painful throat	○ Yes ○ No		
Congested or stuffy nose	○ Yes ○ No		
Runny or dripping nose	○ Yes ○ No		
Diarrhea	○ Yes ○ No		
Weak or tired	○ Yes ○ No		
Loss of smell	○ Yes ○ No		
Loss of taste	○ Yes ○ No		

Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument)

○ Mild ○ Moderate ○ Severe ○ Very Severe

Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities)

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much

8. If you have not had diagnosed or suspected COVID-19 illness, have you had any of the following symptoms since our last call?

For participants who do not report diagnosed or suspected COVID-19:

	A. Have you experienced worsening of this symptom compared to your usual state of health?	**B. When the symptom was at its worst, how much did it bother you, on a scale of 1 to 5? (1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = quite a bit, 5 = very much)**	**C. How long, in days, did the symptom last?**
Fever	○ Yes ○ No		
Trouble breathing	○ Yes ○ No		
Chest congestion	○ Yes ○ No		
Chest tightness	○ Yes ○ No		
Dry or hacking cough	○ Yes ○ No		
Wet or loose cough	○ Yes ○ No		
Body aches or pains	○ Yes ○ No		
Chills or shivering	○ Yes ○ No		
Sore or painful throat	○ Yes ○ No		
Congested or stuffy nose	○ Yes ○ No		
Runny or dripping nose	○ Yes ○ No		
Diarrhea	○ Yes ○ No		
Weak or tired	○ Yes ○ No		
Loss of smell	○ Yes ○ No		
Loss of taste	○ Yes ○ No		
Overall, when these symptoms were at their worst, when you had these symptoms, how bad or bothersome were they? (Patient Global Rating of Flu Severity Instrument) ○ Mild ○ Moderate ○ Severe ○ Very Severe			
Overall, when these symptoms were at their worst, did they interfere with your daily activities? (Patient Global Assessment of Interference with Daily Activities) ○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit ○ Very much			

9. If you had any of the symptoms we talked about, did you take any medicines?

- ○ Yes
- ○ No

If yes:

Medicine	Did you take it?	Was is prescribed by health care professional?	What was the date when you started to take it?	What was the total number of days that you took it?	What was the specific name of the medication(s)?
Acetaminophen, Tylenol	○ Yes ○ No	○ Yes ○ No			
Ibuprofen, Motrin, Advil, Aleve	○ Yes ○ No	○ Yes ○ No			
Cough medicine, Robitussin	○ Yes ○ No	○ Yes ○ No			
"Cold and Flu" medicine	○ Yes ○ No	○ Yes ○ No			
Antibiotic (e.g., azithromycin, augmentin, ciprofloxacin)	○ Yes ○ No	○ Yes ○ No			
Oral corticosteroids (e.g., prednisone, prednisolone, methylprednisone)	○ Yes ○ No	○ Yes ○ No			
Inhaled corticosteroids (e.g., flovent, symbicort, Advair)	○ Yes ○ No	○ Yes ○ No			
Other medicines	○ Yes ○ No	○ Yes ○ No			