Q (select one): How do you feel physically right now?

1. I feel physically normal
2. I'm not feeling quite right

If "I'm not feeling quite right" show:

Q (select one): Do you have a fever or feel too hot?
1. No
2. Yes

Q (select one): Do you feel chills or shivers (feel too cold)?
1. No
2. Yes

Q (number entry): If you are able to measure it, what is your temperature?

Q (select one): Do you have a persistent cough (coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours)?
1. No
2. Yes

Q (select one): Are you experiencing unusual fatigue?
1. No
2. Mild fatigue
3. Severe fatigue - I struggle to get out of bed

Q (select one): Do you have a headache?
1. No
2. Yes

If yes,

Q (select one): How often are you experiencing headaches?
1. All of the day
2. Most of the day
3. Some of the day

Q (select one): Have you felt nausea or experiencing vomiting?
1. No
2. Yes

Q (select one): Are you experiencing dizziness or light-headedness?
1. No
2. Yes

Q (select one): Are you experiencing unusual shortness of breath or have trouble breathing?
1. No
2. Yes. Mild symptoms - slight shortness of breath during ordinary activity.
3. Yes. Significant symptoms - breathing is comfortable only at rest.
4. Yes. Severe symptoms - breathing is difficult even at rest.

Q (select one): Do you have a sore or painful throat?
1.No
2.Yes

Q (select one): Do you have loss of smell/taste?
1. No
2. Yes

Q (select one): Do you have an unusually hoarse voice?
1. No
2.Yes

Q (select one): Are you feeling unusual chest pain or tightness in your chest?
1.No
2.Yes

Q (select one): Do you have unusual abdominal pain or stomach ache?
1.No
2.Yes

Q (select one): Are you experiencing diarrhea?
1.No
2.Yes

If yes, **Q (select one):** How many loose stools in the last 24 hours?
1. 1-2
2. 3-4
3. 5+

Q (select one): Do you have unusual strong muscle pains or aches?
1. No
2. Yes

Q (select one): Have you had raised, red, itchy, welts on the skin or sudden swelling of the face or lips?
1. No
2. Yes

Q (select one): Have you had any red/purple sores or blisters on your feet, including your toes?
1. No
2. Yes

Q (select one): Do you have any of the following symptoms: confusion, disorientation, or drowsiness?
1. No
2. Yes

Q (select one): Do your eyes have any unusual eye-soreness or discomfort (e.g. light sensitivity, excessive tears, or pink/red eye)?
1. No
2. Yes

Q (select one): Have you been skipping meals?
1. No
2. Yes

Q (long text entry): Any there other important symptoms you want to share with us?

Q (select one): Where are you right now?
1. I'm at home. I have not been to the clinic or hospital for suspected COVID symptoms
2. I am at the clinic or hospital with suspected COVID symptoms
3. I am back from the clinic or hospital, I'd like to tell you about my treatment
4. I am back from the clinic or hospital, I've already told you about my treatment

If "I am in the hospital with suspected COVID symptoms" OR "I am back from the hospital, I'd like to tell you about my treatment" show:

Q (select one): What treatment are you (did you) receiving right now?
1. None
2. Oxygen and fluids* (*Breathing support through an oxygen mask, no pressure applied)
3. Non-invasive ventilation* (*Breathing support through an oxygen mask, which pushes oxygen into your lungs)
4. Invasive ventilation* (*Breathing support through an inserted tube. People are usually asleep for this procedure)
5. Other

If "Other" show:

Q (text): What medical treatment are you receiving?