II. COVID Timing, Symptoms and Complications

1. **Were you ill with COVID symptoms more than once?** (check one) [repeat_illness]
   1 Yes
   0 No

If identifies as female, then:

2. **Did you have COVID while you were pregnant?** (check one) [pregnant_any]
   1 Yes
   0 No

   If yes, then:

   2.1 Which trimester were you in? (check one) [pregnant_trimester]
   1 First
   2 Second
   3 Third

For remaining questions, refer to experiences during your most significant illness experience [repeat_illness_yes]

3. **When did you first become ill with COVID?** (drop down) [onset_date]
   1, February 2020
   2, March 2020
   3, April 2020
   4, May 2020
   5, June 2020
   6, July 2020
   7, August 2020
   8, September 2020
   9, October 2020
   10, November 2020
   11, December 2020
   12, January 2021
   13, February 2021
   14, March 2021
   15, April 2021
   16, May 2021
   0, None of these

4. **How long were you ill with COVID-19 (in days)** (number) [illness_length]
   (not a required response, as illness may not be resolved at time of assessment; later question addresses this)

5. **What symptoms did you experience while you were ill with COVID?** (check all that apply) [symptoms_all]

   1 Fever (>100.4 F/38 C)
   2 Chills or Shaking
   3 Cough
   4 Shortness of Breath/Difficulty Breathing
   5 Wheezing
   6 Chest Pressure/Chest Pain

7 Sore Throat
8 Runny Nose/Sinus Congestion
9 Sneezing
10 Diarrhea (>=3 loose/looser than normal stools/24 hr. period)
11 Muscle Pain/Body Aches
12 Headache
13 Partial Loss of Smell (Partial Anosmia)
14 Complete Loss of Smell (Anosmia)
15 Partial Loss of Taste (Partial Ageusia)
16 Complete Loss of Taste (Ageusia)
17 Nausea or Vomiting
18 Bluish Lips/Face
19 Confusion or Inability to Arouse
20 Unusual Fatigue/Lethargy
21 Eye Redness with or without Discharge
22 Ear pain
23 Skin rash or Skin ulcers
24 Other
Please specify other: _____ [ncipr_symptoms_all_other_d]
0 None of these apply

If yes, then:

5.1 Was your fever ever greater than 103.0 F/39.4 C? (check one) [ncipr_fever_level]
1 Yes
0 No

If yes, then:

5.2 How long did you experience Fever? (check one) [ncipr_symptoms_all_01_days2]
1 Less than 24 hours
2 24 to 48 hours
3 48 to 72 hours
4 More than 72 hours

If 3 selected, then:

5.3 Please describe your type of cough: (check one) [cough_type]
1 dry
2 wet
3 other

If 3 selected, then:

5.3.1 Please specify other: (open field) [cough_type_other]

6. Which medical complications did you experience? (check all that apply) [symptoms_med_complicat]
1 Pneumonia (Bacterial or Viral)
2 Inadequate Oxygen or Hypoxia
3 Water in the Lungs (Pleural effusion)
4 Collapsed Lung (Pneumothorax)
5 Acute Respiratory Distress Syndrome
6 Sepsis (serious infection that causes your immune system to attack your body)
7 Heart Inflammation (Endocarditis, Myocarditis, Pericarditis)
8 Cardiac Problems (Cardiomyopathy, Cardiac ischemia/arrhythmia, heart failure)

9 Kidney Injury or Failure
10 Liver Dysfunction
11 Bleeding in digestive tract (Gastrointestinal Hemorrhage)
12 Hyperglycemia/ Hypoglycemia (Abnormal Blood Sugar)
13 Stroke / Cerebrovascular accident
14 Seizure
15 Inflammation or infection of the brain or meninges (Meningitis / Encephalitis)
16 Anemia (Lack of red blood cells or hemoglobin)
0 None of these

7. Maximum temperature recorded (Please be sure to indicate temperature scale i.e. ºF or ºC): (number, incl. decimals) [max_temp]

8. Lowest oxygen saturation recorded (if you don't know, please enter 'N/A") (number, incl. decimals) [min_osat]
999 Unsure

9. What was the most concerning COVID symptom or medical complication that you experienced? (check one) [symptom_worst]
1 Fever
2 Chills or Shaking
3 Cough
4 Difficulty Breathing/Chest Pressure
5 Loss of Taste or Smell
6 Sore Throat
7 Runny Nose/Sinus Congestion
8 Diarrhea
9 Muscle Pain/Body Aches
10 Headache
11 Fatigue
12 Nausea/Vomiting
13 Seizure or Loss of Consciousness
14 No symptoms experienced
15 Other, specify

If 15, then:
9.1: Please specify other: (textfield) [ncipr_symptom_worst_other]

10. Did you experience the following? (check all that apply) [symptoms_events]
1 Stayed in bed all day
2 Confined myself to a room away from my family and housemates
3 Stopped eating
4 Sleep disruption
5 Extreme loss of energy
6 Very anxious that I would not recover from COVID illness
7 Other,
Please specify other: [symp_events_other] _____
0 None of these apply

for all endorsed in list:
For how many days did you experience: (*insert item from symptoms_events*)? [symptoms_events_*item#*_days}
(repeat for each symptom endorsed)

11. How severe was your COVID illness? (check one) [how_severe_self]

1 Very mild
2 Mild to moderate
3 Moderate to severe
4 Severe to Extreme
5 Life-threatening
999 Unsure

Contains items 6-16 (section II "COVID Timing, Symptoms and Complications") and was renumbered from the full document "Novel Coronavirus (COVID) Illness – Patient Report (NCI-PR)"