Symptoms

Memory Symptoms

Have you experienced any **MEMORY RELATED SYMPTOMS** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following memory symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Short-term memory loss (memory that lasts ~30 seconds, i.e. remembering a phone number before writing it down, or forgetting you're in the middle of a task)
- ☐ Long-term memory loss (long-term memory can be anything from remembering yesterday, forgetting you've done a task, forgetting recently learned information, or forgetting your third-grade experience)
- ☐ Not being able to make new memories
- ☐ Forgetting how to do routine tasks (tying your shoe laces, washing your hands)
- ☐ None of the above
- ☐ Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6
Memory symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐

Cognitive Function/Brain Fog Symptoms

Have you experienced issues with **BRAIN FOG** (inability to focus, think clearly, plan, process, understand, and maintain a coherent stream of thought; abnormally slow or fast thoughts) since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following brain fog/cognitive functioning symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Difficulty with executive functioning (planning, organizing, figuring out the sequence of actions, abstracting)
- ☐ Agnosia (failure to recognize or identify objects despite intact sensory functioning)
- ☐ Difficulty problem-solving or decision-making

- [ ] Difficulty thinking
- [ ] Thoughts moving too quickly
- [ ] Slowed thoughts
- [ ] Poor attention or concentration
- [ ] I did NOT have any Brain Fog symptoms
- [ ] Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Month 6
Brain fog/cognitive functioning symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐

Changes to Daily/Functional Abilities due to memory loss or brain fog

Have you felt significantly limited or unable to do any of the following due to **MEMORY LOSS OR BRAIN FOG** (including issues with attention, cognitive functioning, and awareness) specifically? *

	Severely unable	Moderately unable	Mildly unable	Able	app

Drive	○	○	○	○	
Watch children	○	○	○	○	
Cook or use hot items	○	○	○	○	
Feed yourself	○	○	○	○	
Shower or bathe regularly	○	○	○	○	

	Severely unable	Moderately unable	Mildly unable	Able	apl
Make serious decisions	○	○	○	○	
Leave the house and return without getting lost	○	○	○	○	
Remember the correct month or year	○	○	○	○	
Have conversations with others	○	○	○	○	
Maintain your medication schedule (forgetting to take medication or forgetting you've taken medication)	○	○	○	○	

	Severely unable	Moderately unable	Mildly unable	Able	apl
Work	○	○	○	○	
Follow simple instructions	○	○	○	○	
Communicate your thoughts and needs	○	○	○	○	

Other

	○	○	○	○	

	Severely unable	Moderately unable	Mildly unable	Able	apl

Optional: If you have other areas of your life that were affected by

memory loss or brain fog, please include them here. Please note whether they were mildly, moderately, or severely limiting.

Optional: Please use this space to describe examples of your brain fog, memory loss, and attention span.
Please do not include any identifying information (such as name or location).

Emotional/Behavioral Changes

Emotional and Behavioral Changes

Compared to how you felt before COVID, have you experienced an increase in any of the following? *

- [ ] Difficulty controlling your emotions
- [ ] Lack of inhibition (difficulty controlling your behavior)

- [ ] Irritability
- [ ] Anger
- [ ] Impulsivity (acting on a whim without self-control)
- [ ] Aggression
- [ ] Euphoria (a feeling or state of intense excitement and happiness)
- [ ] Delusions
- [ ] Depression
- [ ] Apathy (lack of feeling, emotion, interest, or concern)
- [ ] Suicidality
- [ ] Mood swings
- [ ] Anxiety
- [ ] Mania (abnormally elevated/excited mood, decreased need for sleep, occasionally with delusions)
- [ ] Hypomania (a milder form of mania)
- [ ] Tearfulness
- [ ] Sense of doom
- [ ] None of the above
- [ ] Other

Optional: Please use this space to describe examples of your emotional changes during your illness.
Please do not include any identifying information (name, location, etc.).

Optional: If you had any of these emotional experiences **pre**-COVID,

please describe how they differed **post**-COVID.

Please do not include any identifying information (name, location, etc.).

Speech and Other Language Issues

Speech and Language Issues

Have you experienced any issues with **SPEECH AND LANGUAGE** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following speech and language symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Difficulty finding the right words while speaking/writing
- ☐ Difficulty communicating verbally
- ☐ Difficulting speaking in complete sentences
- ☐ Speaking unrecognizable words
- ☐ Difficulty communicating in writing
- ☐ Difficulty processing/understanding what others say

- [ ] Difficulty reading/processing written text
- [ ] (If applicable) changes to your non-primary (second/third) language skills
- [ ] None of the above
- [ ] Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	M
Speech/language issues	☐	☐	☐	☐	☐	☐	☐	☐	

Do you speak multiple languages? *

- ○ Yes
- ○ No

Optional: Please use this space to describe examples of your language issues, including speech, writing, reading, and listening to words. Please include any changes to your speech/language that are not mentioned above. For instance, if you speak multiple languages and have noticed different problems with your primary and non-primary

language.

Headaches

Headaches

Have you experienced any new **HEADACHES OR RELATED ISSUES** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

- ☐ Headaches, at the base of the skull
- ☐ Headaches, in the temples
- ☐ Headaches, behind the eyes
- ☐ Headaches, diffuse (entire brain)
- ☐ Headaches/pain after mental exertion
- ☐ Headaches, other
- ☐ Sensation of brain warmth/"on fire"

- [ ] Sensation of brain pressure
- [ ] Migraines
- [ ] Stiff neck
- [ ] None of the above

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6
Headaches and related symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐

Sense of Smell and Taste

Sense of Smell and Taste

Have you experienced any changes to your **SENSE OF SMELL OR TASTE** since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

- [ ] Loss of smell
- [ ] Phantom smells (imagining/hallucinating smells - smelling things that aren't there)
- [ ] Heightened sense of smell
- [ ] Altered sense of smell
- [ ] Loss of taste
- [ ] Phantom taste (imagining/hallucinating tastes - tasting things when there's nothing in your mouth)
- [ ] Heightened sense of taste
- [ ] Altered sense of taste
- [ ] None of the above

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Month 6	M
Changes to sense of smell and taste	☐	☐	☐	☐	☐	☐	☐	☐	☐	

If you had phantom tastes, please describe them:

If you had phantom smells, please describe them:

Tremors and Vibrating Sensations

Tremors and Vibrating Sensations

Have you experienced any **TREMOR OR VIBRATION SENTATIONS** since the start of your COVID-19 illness? *

Tremor: Involuntary, rhythmic muscle contraction leading to shaking movements in one or more parts of the body
Vibration sensation: A buzzing feeling, when you feel like your muscles, fingers, or legs are vibrating or shaking inside, but you don't see the movement

- ◯ Yes
- ◯ No

Which of the following symptoms have you experienced since the start of your COVID-19 illness? *

Please specify the location on your body in the text box. If multiple locations, please separate them with a comma (i.e. leg, torso, hand).

☐ _____ Tremors

☐ _____ Vibrating sensations

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	**Week 1**	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	M
Tremors	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Vibrating Sensations	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Please use this space to describe examples of your tremors or body vibration/shaking during your illness.
Please do not include any identifying information (such as name or location).

Sleeping issues

Sleeping issues

Have you experienced any **SLEEPING ISSUES** since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following sleeping issues have you experienced since the start of your COVID-19 illness? *

- ☐ Lucid dreams (dreams where you are aware you are dreaming or have some control over what you dream about)
- ☐ Vivid dreams
- ☐ Nightmares
- ☐ Insomnia
- ☐ Night sweats
- ☐ Restless leg syndrome
- ☐ Awakened by feeling like you couldn't breathe
- ☐ Sleep apnea

☐ Other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	M
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sleep apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	
All the other sleeping symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	

If you have/had insomnia, which best describes the type of insomnia? *

- ☐ Difficulty falling asleep
- ☐ Waking up early in the morning
- ☐ Waking up several times during the night
- ☐ None of the above

What is causing/caused your insomnia? *

- ☐ Pain

- [ ] Sensitivity to outside light/noise
- [ ] Other physical discomfort
- [ ] Anxiety/depression/racing thoughts
- [ ] Difficulty breathing
- [ ] A sensation of adrenaline/energy
- [ ] A sensation like the virus was keeping me awake
- [ ] Other

Hallucinations

Hallucinations

Have you experienced any **HALLUCINATIONS** (visual, hearing, or touch) since the start of your COVID-19 illness? *

- ○ Yes
- ○ No

Which of the following hallucinations have you experienced since the start of your COVID-19 illness? *

- [ ] Visual (seeing) Hallucinations
- [ ] Auditory (hearing) Hallucinations
- [ ] Tactile (touch) Hallucinations
- [ ] Hallucinations, other

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	Week 1	Week 2	Week 3	Week 4	**Month 2**	Month 3	Month 4	Month 5	Mont 6
Hallucinations	☐	☐	☐	☐	☐	☐	☐	☐	☐

Weakness, numbness, tingling, coldness, and other sensations

Weakness, numbness, tingling, coldness, and other sensations

Which of the following **NEUROLOGICAL SENSATION SYMPTOMS** have you experienced since the start of your COVID-19 illness, if any? *

Please specify the location on your body in the text box. If multiple locations, please separate them with a comma (i.e. hand, leg, foot).

- ☐ Skin sensations: burning, tingling, or itchiness without rash
- ☐ [ ] Numbness/loss of sensation
- ☐ Numbness/weakness on one side of the body only

- [ ] Coldness
- [ ] Tingling/prickling/pins and needles sensation
- [ ] Electrical zaps/electrical shock sensation
- [ ] Facial paralysis (please indicate where on face was paralyzed)
- [ ] Sensation of facial pressure/numbness, left side
- [ ] Sensation of facial pressure/numbness, right side
- [ ] Sensation of facial pressure/numbness, other:
- [ ] Weakness
- [ ] None of the above

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5
All neurological sensations	☐	☐	☐	☐	☐	☐	☐	☐	☐

Temperature Issues

Temperature Issues

Have you experienced any **TEMPERATURE ISSUES** (including heat intolerance, chills, high/low temperature) since the start of your COVID-19 illness? *

- ◯ Yes
- ◯ No

Did you experience any of the following **TEMPERATURE ISSUES** since the start of your COVID-19 illness? *

- ☐ Temperature lability (quick swings in and out of fever or elevated temperature)
- ☐ Heat intolerance
- ☐ Other temperature issues (not listed above or below)

If you experienced any of the following temperature issues, when did you experience the following symptoms? *

Please mark symptoms for the first 4 weeks, then months (if you haven't yet reached a week/month, please leave it blank). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4
Elevated temperature (98.8-100.4 degrees Fahrenheit, 37.1-37.9 Celsius)	☐	☐	☐	☐	☐	☐	☐	☐
Fever (100.4 degrees Fahrenheit / 38 degrees Celsius or above)	☐	☐	☐	☐	☐	☐	☐	☐
Low temperature	☐	☐	☐	☐	☐	☐	☐	☐
Chills/flushing/sweats	☐	☐	☐	☐	☐	☐	☐	☐
All other temperature issues	☐	☐	☐	☐	☐	☐	☐	☐

If you had a low temperature, what was your lowest temperature? Please input number only.

☐

If you had a high temperature, what was your highest temperature? Please input number only.

☐

Cardiovascular Symptoms

Cardiovascular Symptoms

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable), even if you have only experienced these symptoms for part of a week or month.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Mont 5
Tachycardia (high heart rate, >90 beats per minute)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bradycardia (low heart rate, <60 beats per minute)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart palpitations (sensation or awareness of your heart beating. Feeling like your heart is racing, thumping or skipping beats)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abnormally high blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abnormally low blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Visibly inflamed/bulging veins	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fainting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots (Thrombosis)	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you had tachycardia and were able to measure it, what was the maximum heart rate (in bpm) that you measured, **at rest**?

If you had tachycardia and were able to measure it, what was the maximum heart rate (in bpm) that you measured, **at exertion** (during physical activity)?

If you had tachycardia and were able to measure it, was your heart rate higher when standing compared to sitting?

- ◯ Yes, it was higher when I was standing
- ◯ No, it was higher when I was sitting
- ◯ It was about the same while standing or sitting

If you had tachycardia and were able to measure it, how much did your heart rate generally change from lying position to standing, last time you measured? (In BPM, beats per minute)

All Other Symptoms - Timecourse

This section has multiple groups of questions about multiple symptoms/issues organized by body area (**Generic Issues, Gastrointestinal issues, Respiratory and sinus symptoms, ear/hearing symptoms, eye symptoms, Reproductive and urinary symptoms, skin and allergy symptoms, and muscle and joint issues**)

Did you experience these symptoms, and when did you experience them? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it. **If you experienced none of the symptoms in a set, select the checkbox (None of the below issues apply to me) above the grouped set.**

Generic Issues

☐ None of the below generic symptoms apply to me

When did you experience these symptoms? *

Please mark symptoms for the first 4 weeks, then months (if applicable). Even if you have only experienced these symptoms for part of a week or month, please select it.

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4
Dizziness / vertigo / unsteadiness or balance issues	☐	☐	☐	☐	☐	☐	☐	☐
Neuralgia (nerve pain)	☐	☐	☐	☐	☐	☐	☐	☐
Seizures (confirmed)	☐	☐	☐	☐	☐	☐	☐	☐
Seizures (suspected)	☐	☐	☐	☐	☐	☐	☐	☐
Episodes of breathing difficulty/gasping for air when your oxygen saturation is normal	☐	☐	☐	☐	☐	☐	☐	☐
Low oxygen levels (<94%)	☐	☐	☐	☐	☐	☐	☐	☐
New/unexpected anaphylaxis reaction	☐	☐	☐	☐	☐	☐	☐	☐
Acute (sudden) confusion/disorientation	☐	☐	☐	☐	☐	☐	☐	☐
Slurring words/speech	☐	☐	☐	☐	☐	☐	☐	☐
High blood sugar (if measured)	☐	☐	☐	☐	☐	☐	☐	☐
Low blood sugar (if measured)	☐	☐	☐	☐	☐	☐	☐	☐

Gastrointestinal Issues

☐ None of the below gastrointestinal symptoms apply to me

Gastrointestinal Issues

N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Mor 5

Constipation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Loss of Appetite	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdominal pain	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Esophagus Burning / gastroesophageal reflux / acid reflux	☐	☐	☐	☐	☐	☐	☐	☐	☐

Respiratory and Sinus Symptoms

☐ None of the below respiratory and sinus symptoms apply to me

Respiratory and Sinus Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Mont 3
Dry cough	☐	☐	☐	☐	☐	☐	☐
Cough with mucus production	☐	☐	☐	☐	☐	☐	☐
Coughing up Blood	☐	☐	☐	☐	☐	☐	☐
Shortness of Breath	☐	☐	☐	☐	☐	☐	☐
Tightness of Chest	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐	☐	☐	☐
Pain/burning in chest	☐	☐	☐	☐	☐	☐	☐

Rattling of breath	☐	☐	☐	☐	☐	☐	☐
Sore Throat	☐	☐	☐	☐	☐	☐	☐
Other ☐	☐	☐	☐	☐	☐	☐	☐

Ear and Hearing Symptoms

☐ None of the below ear and hearing symptoms apply to me

Ear and Hearing Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	M
Hearing loss	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Tinnitus	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other ear/hearing issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Eye and Vision Symptoms

☐ None of the below eye and vision symptoms apply to me

Eye and Vision Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	M

Vision symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	[
Other eye symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	[

Reproductive and Urinary Symptoms

☐ None of the below reproductive and urinary symptoms apply to me

Reproductive and Urinary Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Mont 5
All menstrual/period issues	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bladder control issues	☐	☐	☐	☐	☐	☐	☐	☐	☐

Skin and Allergy Symptoms

☐ None of the below skin and allergy symptoms apply to me

Skin and Allergy Symptoms

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Mont 3
Peeling skin	☐	☐	☐	☐	☐	☐	☐

Petechiae (tiny purple, red, or brown spots on the skin, usually on arms, legs, stomach, buttocks, and occasionally inside mouth or on eyelids)	☐	☐	☐	☐	☐	☐	☐
COVID toes (discoloration, swelling, painful, or blistering toes)	☐	☐	☐	☐	☐	☐	☐
Dermatographia (writing on your skin causes red lines where you scratched)	☐	☐	☐	☐	☐	☐	☐
New allergies (food, chemical, environmental, etc)	☐	☐	☐	☐	☐	☐	☐
Skin rashes	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Muscle and Joint issues

☐ None of the below muscle and joint symptoms apply to me

Muscle and Joint issues

	N/A	Week 1	Week 2	Week 3	Week 4	Month 2	Month 3	Month 4	Month 5	Mon 6
Muscle spasms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle aches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Joint pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bone ache or burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

All Other Symptoms - Checkbox

All Other Symptoms

Have you experienced any of these symptoms since the start of your COVID-19 illness? *

(Please choose all options that apply)

- [ ] Inability to cry
- [ ] Inability to yawn
- [ ] Lump in throat/difficulty swallowing
- [ ] Changes in the voice
- [ ] Coughing up Blood
- [ ] Feeling like you aren't real/like you're observing yourself from outside your body (depersonalization)
- [ ] Feeling like the world isn't real (derealization)
- [ ] Extreme thirst
- [ ] None of the above

Ear and Hearing

- [ ] Ear pain
- [ ] Changes to the ear canal (such as pressure, blockage, burning, swelling)
- [ ] Numbness/loss of sensation
- [ ] Sensitivity to noise
- [ ] Other ear/hearing symptoms
- [ ] None of the above

Eye and Vision

- [ ] Vision symptoms - Blurred vision
- [ ] Vision symptoms - Double vision
- [ ] Vision symptoms - Sensitivity to light
- [ ] Vision symptoms - Tunnel vision
- [ ] Vision symptoms - Total loss of vision
- [ ] Eye pressure or pain
- [ ] Pink eye (conjunctivitis)
- [ ] Bloodshot eyes
- [ ] Dry eyes
- [ ] Redness on the outside of eyes
- [ ] Floaters
- [ ] Seeing things in your peripheral vision
- [ ] Other eye issues:
- [ ] None of the above

Reproductive and Urinary

- [ ] Early Menopause
- [ ] Post-Menopausal bleeding/spotting
- [ ] Abnormally heavy periods/clotting
- [ ] Abnormally irregular periods
- [ ] Other menstrual issues
- [ ] Decrease in size of testicles/penis
- [ ] Pain in testicles

- [ ] Other semen/penis/testicles issues
- [ ] Sexual dysfunction (difficulty maintaining erection, vaginal dryness, difficulty orgasming)
- [ ] Urinary issues, other
- [ ] None of the above

Gastrointestinal

- [ ] Feeling full quickly when eating
- [ ] Abdominal pain
- [ ] Hyperactive bowel sensations
- [ ] None of the above

Skin and Allergy

- [ ] New allergies (food, chemical, environmental, etc)
- [ ] Heightened reaction to old allergies
- [ ] Itchy skin
- [ ] Itchy eyes
- [ ] Itchy, other
- [ ] Brittle/discolored nail
- [ ] Shingles
- [ ] None of the above

Symptom Course

How severe were/are your symptoms over the course of the weeks/months? *

If you experienced multiple severities for symptoms within the time period, select the most severe within that time period.

	No symptom	Very Mild	Mild	Moderate	Severe	Very Severe
Week 1	○	○	○	○	○	○
Week 2	○	○	○	○	○	○
Week 3	○	○	○	○	○	○
Week 4	○	○	○	○	○	○
Month 2	○	○	○	○	○	○

	No symptom	Very Mild	Mild	Moderate	Severe	Very Severe
Month 3	○	○	○	○	○	○
Month 4	○	○	○	○	○	○
Month 5	○	○	○	○	○	○
Month 6	○	○	○	○	○	○
Month 7+	○	○	○	○	○	○

	No symptom	Very Mild	Mild	Moderate	Severe	Very Severe

Which of these descriptions appropriately describes your experience with relapses, and your symptom course overall? Please select all that apply: *

☐ I don't experience relapses/have not yet experienced relapses.

- [ ] My relapses happen in a regular pattern (monthly, daily, or weekly).
- [ ] My relapses happen in an irregular pattern (randomly).
- [ ] My relapses happen in response to a trigger (stress, alcohol, exercise/exertion, etc).
- [ ] My relapses are getting shorter/easier over time.
- [ ] My relapses are getting longer/harder over time.
- [ ] My relapse severity has stayed about the same over time.
- [ ] Overall, my symptoms have slowly gotten better over time.
- [ ] Overall, my symptoms have stayed about the same over time.
- [ ] Overall, my symptoms have slowly worsened over time.
- [ ] I got worse rapidly.
- [ ] I got better rapidly.
- [ ] Other

Which of these trigger a relapse or worsening of symptoms? Please select all that apply: *

- [ ] Stress
- [ ] Alcohol
- [ ] Caffeine
- [ ] Heat
- [ ] Period/menstruation
- [ ] Week before period/menstruation
- [ ] Exercise
- [ ] Physical activity
- [ ] Mental activity
- [ ] Other

How would you rate how you feel today, on a scale of 0-100% (with 100% being your pre-COVID baseline)?

0 10 20 30 40 50 60 70 80 90 100

%

Symptom Severity

List at least **three symptoms** that have been the most debilitating during recovery.
On a scale of 0-10, how severe have they been? (0 is completely fine, 10 is completely debilitating).

0 1 2 3 4 5 6 7 8 9 10

Symptom 1 *

Symptom 2 *

Symptom 3 *

Symptom 4

Symptom 5