Participant Information

Please complete the survey below.

Thank you!

Did you experience any symptoms due to COVID-19?	◯ Yes ◯ No - I was asymptomatic
What day did these symptoms begin?	__________________________________ (Give your closest approximation)
What was the date of your positive test? If you tested positive multiple times, please select the date of your earliest positive test.	__________________________________
Are you still experiencing symptoms due to COVID-19?	Yes No
How long did it take for symptoms from this illness episode to subside?	◯ 3 days ◯ 5 days ◯ 7 days ◯ 10 days ◯ 2 weeks ◯ 3 weeks ◯ 4 weeks or more (Provide your closest approximation)

Which symptoms have you continued to experience? Please select all that apply	Feeling feverish Cough Chills or shivering Sweats Sore throat or itchy/scratchy throat Nausea or vomiting Runny or stuffy nose Muscle or body aches Increased trouble breathing Fatigue Diarrhea Rash Ear pain or ear discharge Loss of sense of taste Loss of sense of smell Headache Chest pain Joint pain Dry eyes and mouth Vertigo Lack of appetite Lowering of vision Fainting Nerve pain Other
Please describe what other symptom(s) you are currently experiencing due to COVID-19.	______________________
Did you access any of the following types of care after your COVID-19 symptoms resolved?	☐ Drive-through testing only ☐ Saw primary care doctor / nurse practitioner / physician assistant ☐ Urgent Care ☐ Emergency room ☐ Admitted to hospital ☐ Admitted to ICU ☐ None of the above ☐ Do not know ☐ Prefer not to say