Form PR-2: Symptom Checklist

[To be completed by participant directly or by RA]

Symptom Checklist Date (dd/mmm/yyyy): _____

For each symptom below, please circle/check one number for frequency and one number for severity thinking about your symptoms over the **past 6 months (baseline visit)/since your last visit**.

Frequency:
How often have you had this symptom?
For each symptom listed below, check a number from:
0 = none of the time
1 = a little of the time
2 = about half the time
3 = most of the time
4 = all of the time

Severity:
How much has this symptom bothered you?
For each symptom listed below, check a number from:
0 = symptom not present
1 = mild
2 = moderate
3 = severe
4 = very severe

No symptoms ☐ True ☐ False

Symptom	**Frequency**	**Severity**
Fatigue / Extreme tiredness	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Dead, heavy feeling after starting to exercise	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Next-day soreness or fatigue after non-strenuous, everyday activities	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Mentally tired after the slightest effort	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Minimum exercise makes you physically tired	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Physically drained or sick after mild activity	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Worsening of symptoms after mild physical activity	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Worsening of symptoms after mild mental activity	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty reading (dyslexia) after mild physical or mental activity	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Worsening of symptoms after mild emotions	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Feeling unrefreshed after you wake up in the morning	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Needing to nap daily	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐

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Problems falling asleep	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Problems staying asleep	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sleeping longer than usual	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Problems remembering things	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty paying attention for a long period of time	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Trouble concentrating	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty finding the right word to say, or expressing thoughts	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty planning	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty understanding things	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Only able to focus on one thing at a time	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Unable to focus attention	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Slowness of thought	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Absent-mindedness or forgetfulness	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Slowed speech	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Hair loss	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Headaches	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sensitivity to noise	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sensitivity to bright lights	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sensitivity to pain	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Numbness in arms or legs or other parts of the body	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Tingling in arms or legs or other parts of the body	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Shooting or stabbing pain or burning in any place on your body	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Feeling internal vibrations	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Unable to focus vision	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Loss of depth perception	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Eye pain	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Dry eye/irritation	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Red or bloodshot eyes	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Itchy eyes	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Seeing flashing lights and/or floaters	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Watery eyes (excessive tears)	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Ear pain	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Ringing in ears/tinnitus	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Problems hearing	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Runny nose	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Stuffed nose/nasal congestion	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Blocked sinus/sinus congestion	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Some smells, foods, medications, or chemicals make you feel sick	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Change in sense of smell	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Change in sense of taste	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty swallowing	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sore throat	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Hoarse voice (change in your voice quality)	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐

Tender/sore lymph nodes	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Flu-like symptoms	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Fever	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sweats	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Chills	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Cough If selected, With sputum production ☐ With blood sputum ☐ Neither ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Pain or aching in your muscles	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Stiffness of muscles	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Pain, stiffness, or tenderness in more than one joint	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Joint swelling	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Pain or aching in your bones	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Muscle twitches	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Muscle cramping	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Muscle weakness	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Swollen legs or ankles	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Slowness of movement	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Feeling unsteady on your feet, like you might fall	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Vertigo/room spinning	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Dizziness	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Feeling disoriented	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Poor coordination	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Sudden loss of consciousness/fainting	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Seizures	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Falls	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Inability to tolerate an upright position	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Tremors	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Mobility aid required	If selected, ☐ Mobility aid required prior to illness?	
Heart beats quickly after standing	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Graying or blacking out after standing	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Chest heaviness/chest tightness/ Chest Pain	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Fast heart rate/palpitations	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Irregular heart beats	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Shortness of breath or trouble catching your breath while sitting	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Shortness of breath or trouble catching your breath while climbing a flight of stairs	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Waking up at night short of breath	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Breathing harder / faster when doing nothing at all	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Pain on breathing	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐

Wheeze	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Bloating	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Abdomen / Stomach pain	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Diarrhea/constipation	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Nausea and/or Vomiting	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Indigestion and/or heartburn	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Bladder and Urinary Problems	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Irritable bowel problems	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Skin changes or rash or hives	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Burning in the mouth or tongue (COVID tongue)	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
COVID toes/fingers (lesions on fingers or toes)	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Cold limbs/hands/feet	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Feeling hot or cold for no reason	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Intolerance to extremes of temperature	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Losing weight without trying	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Gaining weight without trying	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Dysmenorrhea (irregular, missed or unexpected periods)	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Difficulty getting or keeping an erection	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Heightened reaction to known or new allergies	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐
Other (specify):	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐	0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐

In the past week, have you had any symptoms that may be related to COVID-19? *This includes any symptoms that may relate to your long COVID illness.*	☐ Yes ☐ No
If yes:	
In the past week, what was the severity of your overall COVID-19 related symptoms at their worst	☐ Mild ☐ Moderate ☐ Severe
In the past week, how often did you have COVID-19 related symptoms	☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly
In the past week, how much did your COVID-19 related symptoms distress or bother you?	☐ Not at all ☐ A little bit

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	☐ Somewhat ☐ Quite a bit ☐ Very much
Please list the most important/burdensome symptoms (up to 2)	☐ Fatigue ☐ Shortness of breath / shortness of breath on exertion ☐ Chest heaviness / chest pain / chest tightness ☐ Brain fog ☐ Persistent cough ☐ Fast heart rate/palpitations ☐ Insomnia/sleep disturbances ☐ Depression ☐ Anxiety ☐ Post Traumatic Stress Disorder ☐ Other mental health concerns ☐ Bone/muscle/ joint aches or pains ☐ Nausea/vomiting/diarrhea/abdominal pain ☐ Other (specify)

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