Section 1 | Covid related health questions

CORE QUESTIONS **(Covid related health questions)**

Covid-19 symptoms

1. **We are interested in whether you have experienced any symptoms listed below since November 2019. Please complete the table for *any* of the symptoms you have had and in what month(s) you had them.** Please complete for any symptoms and any months that symptoms were experienced irrespective of whether or not you saw a doctor and irrespective of whether or not you were told you had flu, or coronavirus disease 2019 (COVID-19) or any other diagnosis

Source for questions 1-3: Cross cohort questionnaires and flusurvey.

	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020
No cold or flu symptoms						
Decrease in appetite						
Nausea and/or vomiting						
Diarrhoea						
Abdominal pain/tummy ache						
Runny nose						
Sneezing						
Blocked nose						
Sore eyes						
Loss of sense of smell						
Loss of sense of taste						
Sore throat						
Hoarse voice						
Headache (if more often or worse than usual)						
Dizziness						
Shortness of breath affecting normal activities						
New persistent cough						
Tightness in the chest						
Chest pain						
Fever (feeling too hot)						
Chills (feeling too cold)						
Difficulty sleeping						
Felt more tired than normal						
Severe fatigue (e.g. inability to get out of bed)						
Numbness or tingling somewhere in the body						
Feeling of heaviness in arms or legs						
Achy muscles						

*If none ticked in **last week** column, skip to question 3*

2. If you have had any of the symptoms above in the last week:

a. when did the first one start?

1 2 3 4 5 6 7 days ago Can't remember

b. when did the last one finish?

1 2 3 4 5 6 7 days ago Can't remember I still have it/them

c. In the last week have you had shortness of breath (difficulty breathing)?

Source: New York Heart Association scale

No

Yes, but did not affect my normal activities

Yes, did affect my normal activities (e.g. walking short distances)

Yes, even when I was sat or lying down

d. Did you seek medical attention for the symptoms you had in the last week?

Yes No

If no, skip to question 3

***e.* If yes, what kind of medical attention did you access?** *[tick all that apply]*

Contacted NHS 111, by phone or online
Visited pharmacist
Consulted GP/practice nurse over the phone or online
Consulted GP/practice nurse face to face
Walk-in centre
Accident and Emergency
Other, please specify… ..... [free text]

3.

a. In the last week have you had your temperature taken?

Yes; No

If no, skip to question 4

b. Who took your temperature?

A doctor/nurse or other health professional

I did

It was taken by someone else

c. If you can remember, what was the highest temperature reading?

__._^{O}C

4. Have you been in close contact with anyone with COVID-19 in the last <u>two weeks</u>?

Yes, I was in contact with a confirmed/tested COVID-19 case
Yes, I was in contact with a suspected COVID-19 case
No, not to my knowledge

5.

a. Do you think that you have or have had COVID-19?

Yes, confirmed by a positive test
Yes, suspected by a doctor but not tested
Yes, my own suspicions
No
If No, go to question 6

b. If yes, when were you told/when did you think you first had COVID-19?

DD/MM/YYYY

Pre-existing health conditions

6.

a. Are you, or do you, currently have any of the following? (tick all that apply)

Source – publications and NHS shielded categories 06/04/2020

	Tick if yes
Organ transplant recipient	
Diabetes (Type I or II)	
Heart disease or heart problems	
Hypertension (high blood pressure)	
Overweight	
Stroke	
Kidney disease	
Liver disease	
Anaemia	
Asthma	
Other lung condition such as COPD, bronchitis or emphysema	
Cancer	
Condition affecting the brain and nerves (e.g. Dementia, Parkinson's, Multiple Sclerosis)	
A weakened immune system/reduced ability to deal with infections (as a result of a disease or treatment)	
Depression	
Anxiety	
Psychiatric disorder	

b. If yes, please tell us exactly what you have:

Free text box

c. Have you been contacted by letter or text message to say you are **at severe risk from COVID-19 due to an underlying health condition** and should be shielding?

○ Yes (1)

○ No (0)

7. For each of the following questions please respond Yes or No

Source – PRISMA 7 – assuming age and gender is already known by this point

	Yes	*No*
In general, do you have health problems that require you to limit your activities?		

Do you need someone to help you on a regular basis?		
In general, do you have any health problems that require you to stay at home?		
If you need help, can you count on someone close to you?		
Do you regularly use a stick, walker or wheelchair to move about?		

8. Do you currently take any regular medication?

Yes; *No*

There is a Recommended question asking medication detail

9. Have you had a flu jab in the last 12 months?

Yes: *No.*

Mental health

ADULTS (18 years+) only

10. Over the last two weeks, how often have you been bothered by any of the following problems?

Source: PHQ-9

Ask the last question only if safe to use in the population being studied

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead or of hurting yourself in some way				

11. Over the last two weeks, how often have you been bothered by any of the following problems?

Source: GAD-7

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge?				
Not being able to stop or control worrying?				
Worrying too much about different things?				
Trouble relaxing?				
Being so restless that it is hard to sit still?				
Becoming easily annoyed or irritable?				
Feeling afraid as if something awful might happen?				

----------FOR CHILDREN / YOUNG PEOPLE ----------

YOUNG PEOPLE (8 - 17 years) only

12. Please mark the word that shows how often each of these things happens to you. There are no right or wrong answers

Source: RCADS 25

	Never	Sometimes	Often	Always
I feel sad or empty				
I worry when I think I have done poorly at something				
I would feel afraid of being on my own at home				
Nothing is much fun anymore				
I worry that something awful will happen to someone in my family				
I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)				
I worry what other people think of me				
I have trouble sleeping				
I feel scared if I have to sleep on my own				
I have problems with my appetite				
I suddenly become dizzy or faint when there is no reason for this				
I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)				
I have no energy for things				
I suddenly start to tremble or shake when there is no reason for this				
I cannot think clearly				
I feel worthless				
I have to think of special thoughts (like numbers or words) to stop bad things from happening				
I think about death				
I feel like I don't want to move				

I worry that I will suddenly get a scared feeling when there is nothing to be afraid of				
I am tired a lot				
I feel afraid that I will make a fool of myself in front of people				
I have to do some things in just the right way to stop bad things from happening				
I feel restless				
I worry that something bad will happen to me				