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INDIANA UNIVERSITY
SCHOOL OF MEDICINE

COVID-19 Symptom Impact Survey

1. Demographics and Background Information

If you live in the United States, what is your zip code?

If you do not live in the United States, what country do you live in?

How old are you?
* must provide value

What is your gender? Mark all that apply.
* must provide value

- [ ] Female
- [ ] Male
- [ ] A gender not listed

What is or are your racial and ethnic group(s)? Mark all that apply.
* must provide value

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Latino, or Spanish origin
- [ ] Middle Eastern or North African
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Another race or ethnicity not listed above

What do you do for a living?
* must provide value

Expand

What percentage of your work hours do you work from home?

- ( ) 0-25%
- ( ) 26-50%
- ( ) 51-75%
- ( ) 76-100%

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Do you work outside your home *less now* than before the pandemic?

- ○ Yes
- ○ No

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2. COVID-19 Diagnosis

What date did you first start having COVID-19 symptoms?

Today M-D-Y

How did you determine that you had COVID-19?

- ☐ You had a positive COVID-19 test
- ☐ Your doctor diagnosed you as a suspected case of COVID-19
- ☐ You self-diagnosed based on your symptoms
- ☐ Other

Were you ever hospitalized due to COVID-19?

- ○ Yes
- ○ No

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Have you visited the hospital or been hospitalized for COVID-19 symptoms that occurred *two weeks or more* after you first got sick?

- ○ Yes
- ○ No

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3. Medical History

How healthy were you prior to getting COVID-19?

- ○ Very Unhealthy
- ○ Somewhat Unhealthy
- ○ Neither Healthy nor Unhealthy
- ○ Somewhat Healthy
- ○ Very Healthy

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For the next four questions, answer based on your best estimate from your memory, there's no need to look up your medical history.

When you get a cold, about how many days does it usually last?

How many colds can you remember having in the past year?

How many flus can you remember having in the past year?

How may flus do you think you've had in the past 5 years?

Have you been diagnosed with SARS within the past 2 years?

- Yes
- No

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What medicines were you already taking when you got sick with COVID-19?

This can include medicines you take for a chronic disease, seasonal allergies, or for any health purpose. Please select all that apply from the list below, and enter any medicines missing from the list in the blank.

Examples of each type of medicine are in () but please select your type of medicine even if it's not listed as an example. **Please do not list medicines you're taking to help with COVID-19 symptoms, we'll ask about those later.**

Medicines I was already taking right before I got sick with COVID-19 are:

- [ ] Alemtuzumab (Lemtrada)
- [ ] Antihistamines (Allegra, Benadryl, Zyrtec)
- [ ] Anti-inflammatory medication (Zileuton, Zafirlukast)
- [ ] Blood pressure medication
- [ ] Blood thinners or anticoagulants (Eliquis, Pradaxa, Lixiana, Xarelto, Coumadin)
- [ ] Bronchodilator (Albuterol, Tiotropium, Levalbuterol, Ipratropium bromide, Salmeterol)
- [ ] BTK inhibitors (Imbruvica, Calquence, Brukinsa)
- [ ] CBD oil
- [ ] Celebrex
- [ ] Cladribine (Mavenclad)
- [ ] Corticosteroids (Hydrocortisone, Prednisone, Florinef, Orapred)
- [ ] Dimethyl Fumarate (Tecfidera)
- [ ] Fingolimod (Gilenya)
- [ ] Glatiramer Acetate (Copaxone or Glatopa)
- [ ] HIV medication
- [ ] IL-6 pathway inhibitors (RoActemra, Kevzara)
- [ ] Inhaled steroids (Beclomethasone, Fluticasone, Pulmicort, Flunisolide)
- [ ] Hydroxychloroquine
- [ ] Interferon Beta (Avonex, Betaseron, Extavia, Plegridy, Rebif)
- [ ] Medical marijuana
- [ ] Mitoxantrone (Novantrone)
- [ ] Natalizumab (Tysabri)
- [ ] NSAIDs (Aspirin, Ibuprofen, Motrin, Advil)
- [ ] Ocrelizumab (Ocrevus)
- [ ] Teriflunomide (Aubagio)
- [ ] Tocilizumab (Actemra)
- [ ] Vitamin C
- [ ] Vitamin D
- [ ] Zinc
- [ ] Other vitamins
- [ ] Other medications

Please select any underlying medical conditions you have (select all that apply):

- [ ] Asthma
- [ ] Cancer
- [ ] Cardiomyopathy
- [ ] Cerebrovascular disease
- [ ] Chronic kidney disease
- [ ] COPD
- [ ] Coronary artery disease
- [ ] Cystic fibrosis
- [ ] Heart failure
- [ ] High blood pressure
- [ ] HIV
- [ ] Hypertension
- [ ] Liver disease
- [ ] Multiple sclerosis
- [ ] Need to use corticosteroids
- [ ] Need to use other immune weakening medicines
- [ ] Neurologic condition such as dementia
- [ ] Obesity
- [ ] Pregnancy
- [ ] Pulmonary fibrosis
- [ ] Sickle cell disease
- [ ] Smoking
- [ ] Thalassemia
- [ ] Type 1 Diabetes
- [ ] Type 2 Diabetes
- [ ] Immune deficiencies
- [ ] Weakened immune system from blood or bone marrow transplant
- [ ] Weakened immune system from solid organ transplant
- [ ] Other

4. COVID-19 Symptoms

Please select all of the symptoms you've experienced that you believe are due to COVID-19:

- [ ] Abdominal pain

- [ ] Abnormally low temperature
- [ ] Anemia
- [ ] Anxiety
- [ ] Arrhythmia (improper beating of the heart due to electrical impulse problems)
- [ ] Bilateral neck throbbing around lymph nodes
- [ ] Blurry vision
- [ ] Bone aches in extremities
- [ ] Brain pressure
- [ ] Bulging veins
- [ ] Burning sensations
- [ ] Calf cramps
- [ ] Changed sense of taste
- [ ] Changing symptoms
- [ ] Chills but no fever
- [ ] Clogged ears
- [ ] Cold burning feeling in lungs
- [ ] Confusion

- [ ] Congested or runny nose
- [ ] Constant thirst
- [ ] Costochondritis (inflammation of the cartilage that connects a rib to the breastbone)
- [ ] Cough
- [ ] Covid toes (tender or itchy rash or chilblains on the toes or foot)
- [ ] Cracked or dry lips
- [ ] Diarrhea
- [ ] Difficulty concentrating or focusing
- [ ] Difficulty sleeping
- [ ] Dizziness
- [ ] Dry eyes
- [ ] Dry or peeling skin
- [ ] Dry scalp or dandruff
- [ ] Dry throat
- [ ] Ear pain/ear ache
- [ ] Elevated thyroid

- [ ] Extreme pressure at base of head or occipital nerve
- [ ] Eye stye or infection
- [ ] Fatigue
- [ ] Feeling irritable
- [ ] Feeling of burning skin
- [ ] Fever or chills
- [ ] Floaters or flashes of light in vision
- [ ] Foot pain
- [ ] GERD with excessive salivation
- [ ] Goiter or lump in throat
- [ ] Hair loss
- [ ] Hand or wrist pain
- [ ] Headache
- [ ] Heart palpitations (heart skipping a beat or racing)
- [ ] Heat intolerance
- [ ] Herpes, EBV (Epstein-Barr virus), or Trigeminal neuralgia

- [ ] High blood pressure
- [ ] Hormone imbalances
- [ ] "Hot" blood rush
- [ ] Inability to exercise or be active
- [ ] Irregular or skipped menstrual cycles
- [ ] Jaw pain
- [ ] Joint pain
- [ ] Kidney issues or protein in urine
- [ ] Kidney pain
- [ ] Low blood oxygen
- [ ] Low blood pressure
- [ ] Lower back pain
- [ ] Memory problems
- [ ] Menstrual cycles that are heavier or lighter than normal
- [ ] Mid-back pain at base of ribs
- [ ] Mouth sores or sore tongue
- [ ] Muscle or body aches

- [ ] Muscle twitching
- [ ] Nausea or vomiting
- [ ] Neck muscle pain
- [ ] Nerve sensations
- [ ] Neuropathy in feet and hands (weakness, numbness, and pain)
- [ ] Night sweats
- [ ] Painful scalp
- [ ] Partial or complete loss of sense of smell
- [ ] Partial or complete loss of sense of taste
- [ ] Persistent chest pain or pressure
- [ ] Personality change (drastic)
- [ ] Phantom smells
- [ ] Phlegm in back of throat
- [ ] Post nasal drip
- [ ] Rash
- [ ] Reflux or heartburn
- [ ] Sadness

- [ ] Sharp or sudden chest pain
- [ ] Shortness of breath or difficulty breathing
- [ ] Shortness of breath or exhaustion from bending over
- [ ] Sleeping more than normal
- [ ] Sore throat
- [ ] Spikes in blood pressure
- [ ] Swollen hands or feet
- [ ] Swollen lymph nodes
- [ ] Syncope (fainting)
- [ ] Tachycardia (a rapid heartbeat without being active)
- [ ] Thrush (white fungal infection in the mouth or throat)
- [ ] Tinnitus or humming in ears
- [ ] Tremors or shakiness
- [ ] Upper back pain
- [ ] UTI (urinary tract infection)
- [ ] Weight gain

- [ ] Weight loss

Have you experienced any symptoms not listed above?

- ( ) Yes
- ( ) No

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5. Getting Medical Treatment for COVID-19

Have you reached out to your physician or a specialist to get treatment for your COVID-19 symptoms?

- ( ) Yes
- ( ) No

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Has your ability to get medical care been hindered by insurance issues or lack of health insurance?

- ( ) Yes
- ( ) No

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How much has your stress level changed since getting COVID-19?

- ( ) Decreased a lot
- ( ) Decreased a Little
- ( ) Unchanged
- ( ) Increased a Little
- ( ) Increased a Lot

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The World Health Organization defines mental wellness as *"A state of well-being in which the individual realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*

How much do you feel your experiences with COVID-19 have negatively impacted your mental wellness?

- ( ) Not at all
- ( ) A little bit
- ( ) Somewhat
- ( ) Quite a bit
- ( ) Very much

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What is the most difficult thing about having COVID-19?

Expand

In your opinion, what should future research focus on in order to help COVID-19 patients the most?

Expand

Is there anything else you'd like to tell us about your experiences with COVID-19?

Expand

Thank you for your participation!

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