



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

<p>What date did you first start having COVID-19 symptoms?</p>	<input type="text"/>  Today M-D-Y
<p>How did you determine that you had COVID-19?</p>	<input type="checkbox"/> You had a positive COVID-19 test <input type="checkbox"/> Your doctor diagnosed you as a suspected case of COVID-19 <input type="checkbox"/> You self-diagnosed based on your symptoms <input type="checkbox"/> Other
<p>Were you ever hospitalized due to COVID-19?</p>	<input type="radio"/> Yes <input type="radio"/> No
<p>Have you visited the hospital or been hospitalized for COVID-19 symptoms that occurred <i>two weeks or more</i> after you first got sick?</p>	<input type="radio"/> Yes <input type="radio"/> No
<h3>3. Medical History</h3>	
<p>How healthy were you prior to getting COVID-19?</p>	<input type="radio"/> Very Unhealthy <input type="radio"/> Somewhat Unhealthy <input type="radio"/> Neither Healthy nor Unhealthy <input type="radio"/> Somewhat Healthy <input type="radio"/> Very Healthy
<p><i>For the next four questions, answer based on your best estimate from your memory, there's no need to look up your medical history.</i></p>	
<p>When you get a cold, about how many days does it usually last?</p>	<input type="text"/>
<p>How many colds can you remember having in the past year?</p>	<input type="text"/>
<p>How many flus can you remember having in the past year?</p>	<input type="text"/>
<p>How many flus do you think you've had in the past 5 years?</p>	<input type="text"/>
<p>Have you been diagnosed with SARS within the past 2 years?</p>	<input type="radio"/> Yes <input type="radio"/> 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

<input type="checkbox"/> Arrhythmia (improper beating of the heart due to electrical impulse problems)
<input type="checkbox"/> Bilateral neck throbbing around lymph nodes
<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Bone aches in extremities
<input type="checkbox"/> Brain pressure
<input type="checkbox"/> Bulging veins
<input type="checkbox"/> Burning sensations
<input type="checkbox"/> Calf cramps
<input type="checkbox"/> Changed sense of taste
<input type="checkbox"/> Changing symptoms
<input type="checkbox"/> Chills but no fever
<input type="checkbox"/> Clogged ears
<input type="checkbox"/> Cold burning feeling in lungs
<input type="checkbox"/> Confusion
<input type="checkbox"/> Congested or runny nose
<input type="checkbox"/> Constant thirst
<input type="checkbox"/> Costochondritis (inflammation of the cartilage that connects a rib to the breastbone)
<input type="checkbox"/> Cough

<input type="checkbox"/> Covid toes (tender or itchy rash or chilblains on the toes or foot)
<input type="checkbox"/> Cracked or dry lips
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Difficulty concentrating or focusing
<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Dry eyes
<input type="checkbox"/> Dry or peeling skin
<input type="checkbox"/> Dry scalp or dandruff
<input type="checkbox"/> Dry throat
<input type="checkbox"/> Ear pain/ear ache
<input type="checkbox"/> Elevated thyroid
<input type="checkbox"/> Extreme pressure at base of head or occipital nerve
<input type="checkbox"/> Eye stye or infection
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Feeling irritable
<input type="checkbox"/> Feeling of burning skin
<input type="checkbox"/> Fever or chills
<input type="checkbox"/> Floaters or flashes of light in vision

<input type="checkbox"/> Foot pain
<input type="checkbox"/> GERD with excessive salivation
<input type="checkbox"/> Goiter or lump in throat
<input type="checkbox"/> Hair loss
<input type="checkbox"/> Hand or wrist pain
<input type="checkbox"/> Headache
<input type="checkbox"/> Heart palpitations (heart skipping a beat or racing)
<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Herpes, EBV (Epstein-Barr virus), or Trigeminal neuralgia
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hormone imbalances
<input type="checkbox"/> "Hot" blood rush
<input type="checkbox"/> Inability to exercise or be active
<input type="checkbox"/> Irregular or skipped menstrual cycles
<input type="checkbox"/> Jaw pain
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Kidney issues or protein in urine
<input type="checkbox"/> Kidney pain
<input type="checkbox"/> Low blood oxygen

<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Lower back pain
<input type="checkbox"/> Memory problems
<input type="checkbox"/> Menstrual cycles that are heavier or lighter than normal
<input type="checkbox"/> Mid-back pain at base of ribs
<input type="checkbox"/> Mouth sores or sore tongue
<input type="checkbox"/> Muscle or body aches
<input type="checkbox"/> Muscle twitching
<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Neck muscle pain
<input type="checkbox"/> Nerve sensations
<input type="checkbox"/> Neuropathy in feet and hands (weakness, numbness, and pain)
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Painful scalp
<input type="checkbox"/> Partial or complete loss of sense of smell
<input type="checkbox"/> Partial or complete loss of sense of taste
<input type="checkbox"/> Persistent chest pain or pressure
<input type="checkbox"/> Personality change (drastic)
<input type="checkbox"/> Phantom smells

<input type="checkbox"/> Phlegm in back of throat
<input type="checkbox"/> Post nasal drip
<input type="checkbox"/> Rash
<input type="checkbox"/> Reflux or heartburn
<input type="checkbox"/> Sadness
<input type="checkbox"/> Sharp or sudden chest pain
<input type="checkbox"/> Shortness of breath or difficulty breathing
<input type="checkbox"/> Shortness of breath or exhaustion from bending over
<input type="checkbox"/> Sleeping more than normal
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Spikes in blood pressure
<input type="checkbox"/> Swollen hands or feet
<input type="checkbox"/> Swollen lymph nodes
<input type="checkbox"/> Syncope (fainting)
<input type="checkbox"/> Tachycardia (a rapid heartbeat without being active)
<input type="checkbox"/> Thrush (white fungal infection in the mouth or throat)
<input type="checkbox"/> Tinnitus or humming in ears
<input type="checkbox"/> Tremors or shakiness
<input type="checkbox"/> 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

[reset](#)

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

[reset](#)

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!

Make sure to click the SUBMIT button below.

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