COVID-19 PATIENT QUESTIONNAIRE

Introduction Page

Your questionnaire will help your practice to know the impact COVID-19 is having on your health and daily life. It will help your doctor to better manage your healthcare needs. Please take a few minutes to complete the whole questionnaire to help us. If you have not had COVID-19 or any symptoms, it will take about 5 minutes to complete. If you have had COVID-19 or treated for COVID-19, it may take 20 minutes to complete.

1 Have you had any of these symptoms of COVID-19 since January 2020? *(Tick all that apply)*

[ ] No, I have not had any symptoms
[ ] Fever or high temperature
[ ] Persistent dry cough
[ ] Loss or change or smell or taste
[ ] Shortness of breath
[ ] Loss of appetite
[ ] Chest pain
[ ] Fatigue or tiredness
[ ] Aches and pains
[ ] Headache
[ ] Abdominal pain
[ ] Diarrhoea
[ ] Confusion, disorientation, drowsiness

If any symptom is selected → 1.1

1.1 When did your symptoms start? [date]

2 Do you believe that you had COVID-19 infection?

[ ] Yes → 3, 8
[ ] No → 5

3 Have you been diagnosed with COVID-19 or told by a healthcare professional that you may have COVID-19?

[ ] Yes → 4
[ ] No → 5

4 How do you feel physically right now?

[ ] I feel physically normal → 5
[ ] I'm not feeling quite right → 4.1

4.1 Do you have any of these symptoms? *(Tick all that apply)*

[ ] No, I have not had any symptoms
[ ] Fever or high temperature
[ ] Persistent dry cough
[ ] Loss of smell or taste
[ ] Shortness of breath
[ ] Loss of appetite
[ ] Chest pain
[ ] Fatigue or tiredness
[ ] Aches and pains
[ ] Headache
[ ] Abdominal pain
[ ] Diarrhoea
[ ] Confusion, disorientation, drowsiness

If any symptom is selected → 4.2

4.2 When did your symptoms start? [date]

5 Have you been tested for COVID-19?

[ ] Yes → 6
[ ] No → 11

6 6.1 Date of test [date]

6.2 How was this test performed?
[ ] Nose or throat swab
[ ] Blood test
[ ] Other [please specify]

7 What were the results of your COVID-19 test?

[ ] At least one of my tests was positive
[ ] Waiting for test results
[ ] None of my tests was positive

8 What kind of medical attention did you seek for COVID-19 infection or symptoms? *(Tick all that apply)*

[ ] No, I did not seek any medical attention
[ ] Contacted NHS 111 by phone or online
[ ] Consulted GP/practice nurse over the phone or online
[ ] Consulted GP/practice nurse face-to-face
[ ] Visited Accident and Emergency → 9
[ ] Admitted to hospital → 9
[ ] Admitted to intensive or critical care → 9
[ ] Other [please specify]

8.1 If you were admitted or treated in hospital, what treatment did you receive?

[ ] Oxygen
[ ] Pressurised air delivered through face mask
[ ] Invasive ventilation (breathing support through an inserted tube. People are usually asleep for this procedure)
[ ] Organ support or life support
[ ] Other [enter treatment]

9 How many people are in your household including yourself?

[number]
[ ] I don't know
[ ] I live in a care home

10 Have you been exposed to someone with confirmed or suspected COVID-19 infection (such as co-workers, family members, or others)?

[ ] Yes, confirmed COVID-19 case only → 10.1
[ ] Yes, suspected COVID-19 case only
[ ] Yes, both confirmed and suspected COVID-19 cases
[ ] Not that I know of

10.1 Have you been contacted by NHS Test and Trace?

[ ] Yes
[ ] No

11 Were you asked to remain at home for 14 days after travel or exposure to COVID-19?

[ ] No
[ ] Yes → 12.1

11.1 How many weeks or months have you self-isolated?

[number] weeks or [number] months

12 Have you been contact by letter or text message to say you should be shielding?

[ ] No
[ ] Yes → 12.1

12.1 How many weeks or months have you been shielding and not gone out?

[number] weeks or [number] months

13 For each of the following questions please respond Yes or No:

	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?	[ ]	[ ]

13.1 Which one of the following best describes your level of fitness?

[ ] Fit and well (you have no active medical problems, and you exercise occasionally or regularly)
[ ] Managing well (you have medical problems that limit how active you are, but you don't need help with daily activities)
[ ] Frail (you have medical problems that limit how active you are, and you need help with daily activities and personal care)

14 Since March 2020, how often have you done the following?

	Less than usual	No change	More than usual
Interacting with family and friends	[ ]	[ ]	[ ]
Leaving the house	[ ]	[ ]	[ ]
Contacting your doctor	[ ]	[ ]	[ ]
Physical activity e.g. walking, exercise	[ ]	[ ]	[ ]

14.1 Since March 2020, have you changed your diet or medications?

	Yes	No
Your diet	[ ]	[ ]
Your medication	[ ]	[ ]

15 Over the last 2 weeks, how often have you been bothered by the following problems?

	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	[ ]	[ ]	[ ]	[ ]
Feeling nervous, anxious or on edge	[ ]	[ ]	[ ]	[ ]
Not being able to stop or control worrying	[ ]	[ ]	[ ]	[ ]

16 Please tell us about your height and weight.

Height [ ] cm OR [ ] Feet [ ] Inches
Weight [ ] kg OR [ ] stone [ ] pounds

17 Which of the following best describes your ethnicity? *(Tick all that apply)*

[ ] Asian / Asian British
[ ] Black / Black British
[ ] Mixed race - White and Black/Black British
[ ] Mixed race - other
[ ] White - British, Irish, other
[ ] Chinese / Chinese British
[ ] Hispanic or Latino or Spanish origin
[ ] Middle Eastern / Middle Eastern British
[ ] Other [please specify]
[ ] Unknown / Prefer not to say

18 Are you employed?

[ ] Employed → 18.1
[ ] Retired → 18.2
[ ] Student or in school
[ ] Unemployed

18.1 Enter your occupation or job [free text]
18.2 What was your occupation or job? [free text]

19 Do you have any of the following health problems or conditions? *(Tick all that apply)*

[ ] Asthma
[ ] COPD, bronchitis, or emphysema
[ ] Diabetes
[ ] Hypertension (high blood pressure)
[ ] Heart disease or heart failure
[ ] Kidney disease

19.1 Since March 2020, how well do you fell about the condition?

[ ] Better
[ ] No change
[ ] Worse

(If asthma or COPD selected → 20) (If asthma or COPD not selected → 27)

20 Are you currently on any regular medication?

[ ] No → 21
[ ] Yes → 20.1

20.1 How often do you take your regular inhaled medication (not your reliever inhaler)?

[ ] I take regularly (almost every day)
[ ] I take it occasionally (some days)
[ ] I don't take it any more
[ ] Not applicable

21 Has your nurse or doctor provided you with a written plan which tells you how to recognise when your breathing condition is worsening and what you should do?

[ ] Yes
[ ] No, I have not been given advice
[ ] No written information but I have been told what to do

22 In the last 7 days, how many days:

	0	1	2	3	4	5	6	7
Have you had breathing symptoms (e.g. cough, wheeze, shortness of breath)?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Has your breathing condition interfered with your usual activities (e.g. housework, work, school)?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Have you been affected or woken by breathing symptoms?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Have you used your reliever (blue) inhaler?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

23 In the last 12 months, how many times:

Have you needed a course (3+ days) of steroid tablets e.g. prednisolone because your breathing condition got worse? [number]

How many times have you been admitted to hospital because your breathing condition got worse? [number]

How many times have you been treated in an emergency department (A&E) or anywhere other than your GP surgery because your breathing condition got worse? [number]

23.1 If number entered > 0 → How many times since March 2020 [number]

24 These questions measure the impact your breathing condition is having on your daily life.
Please select only one answer for each question.

	0	1	2	3	4	5	
I never cough	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	I cough all the time
I have no phlegm (mucus) on my chest at all	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	My chest is completely full of phlegm (mucus)
My chest does not feel tight at all	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	My chest feels very tight
When I walk up a hill or one flight of stairs I am not breathless	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	When I walk up a hill or one flight of stairs I am very breathless
I am not limited doing any activities at home	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	I am very limited doing activities at home
I am confident leaving my home despite my breathing condition	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	I am not at all confident leaving my home because of my breathing condition
I sleep soundly	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	I don't sleep soundly because of my breathing condition
I have lots of energy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	I have no energy at all

25 Are you given a regular injection medication (usually at hospital) also known as 'biologics' for your breathing condition?

[ ] Yes → 25.1
[ ] No → 26

25.1 Which of these injection medications do you take? *(Tick all that apply)*

[ ] Xolair (Omalizumab)
[ ] Nucala (Mepolizumab)
[ ] Cinqaero (Reslizumab)
[ ] Fasenra (Benralizumab)
[ ] Dupixent (Dupilomab)

27 Would you like to take part in future research?

[ ] Yes → Please enter your email [email address]
[ ] No

Your information will be held securely and will only be used to contact you about research your GP practice is taking part in. For more information on how we handle and protect personal information, visit: https://optimumpatientcare.org/privacy-notice/

Thank you very much for spending the time to answer these questions.
The information will be submitted to your practice to help with your care.