Appendix

Appendix 1

Long COVID-19 study in Fars, Iran

Name: Sex: male /female Phone number:
COVID onset date: Length of hospital stay:
Admission at ICU: Yes/No Date of discharge:
Comorbidities: Yes/No Type of comorbidities:
Responder: patient / immediate family member living with the patient

- **Have experienced any symptoms or complaints or problems during the past week (any symptoms or complaints or problems that you did not have before your COVID-19, but have had ever since after your illness and specifically during the past seven days)?**

1. Muscle weakness Yes /No (mild and tolerable-moderate-sever and incapacitating)
2. Muscle pain Yes /No (mild and tolerable-moderate-sever and incapacitating)
3. Joint pain Yes /No (mild and tolerable-moderate-sever and incapacitating) Which join ……
4. Fatigue Yes /No (mild and tolerable-moderate-sever and incapacitating)
5. Sleep difficulty Yes /No (mild and tolerable-moderate-sever and incapacitating)
6. Anxiety Yes /No (mild and tolerable-moderate-sever and incapacitating)
7. Depression Yes /No (mild and tolerable-moderate-sever and incapacitating)
8. Shortness of breath Yes /No (mild and tolerable-moderate-sever and incapacitating)
9. Chest pain Yes /No (mild and tolerable-moderate-sever and incapacitating)
10. Palpitation Yes /No (mild and tolerable-moderate-sever and incapacitating)
11. Cough Yes /No (mild and tolerable-moderate-sever and incapacitating)
12. Excess sputum Yes /No (mild and tolerable-moderate-sever and incapacitating)
13. Decreased sense of smell Yes /No (mild and tolerable-moderate-sever and incapacitating)
14. Decreased sense of taste Yes /No (mild and tolerable-moderate-sever and incapacitating)
15. Sore throat Yes /No (mild and tolerable-moderate-sever and incapacitating)
16. Headache Yes /No (mild and tolerable-moderate-sever and incapacitating)
17. Dizziness Yes /No (mild and tolerable-moderate-sever and incapacitating)
18. Concentration difficulty Yes /No (mild and tolerable-moderate-sever and incapacitating)
19. Excess sweating Yes /No (mild and tolerable-moderate-sever and incapacitating)
20. Exercise difficulty Yes /No (mild and tolerable-moderate-sever and incapacitating)
21. Walking difficulty Yes /No (mild and tolerable-moderate-sever and incapacitating)
22. Diarrhea Yes /No (mild and tolerable-moderate-sever and incapacitating)
23. Abdominal pain/stomach ache Yes /No (mild and tolerable-moderate-sever and incapacitating)
24. Loss of appetite Yes /No (mild and tolerable-moderate-sever and incapacitating)
25. Weight loss Yes /No (mild and tolerable-moderate-sever and incapacitating) Amount…...Kg
26. Weight gain Yes /No (mild and tolerable-moderate-sever and incapacitating) Amount……Kg
27. Please mention other symptoms or complaints ….
28. Have you been affected by any chronic medical illness/problem after your COVID-19 was resolved (please mention)?.....

- **How would you rate the following items over the past week compared with that before your COVID-19?**

1. Ability to do routine and normal tasks (much worse/somewhat worse/the same as before/ somewhat better/much better)
2. Ability to concentrate and think (much worse/ somewhat worse/the same as before /somewhat better/ much better)
3. Ability to study (much worse/somewhat worse/the same as before/somewhat better/much better)
4. Your overall quality of life (much worse/somewhat worse/the same as before/somewhat better/much better)
5. Hope for the future (much worse/somewhat worse/the same as before/somewhat better/much better)