

Newcastle post-COVID syndrome Follow Up Screening Questionnaire

The purpose of the questionnaire is to identify patients who may benefit from a comprehensive face to face multi-disciplinary assessment if symptoms persist 10-12 weeks after the acute illness.

Patient name:

NHS number:

1. Have you made a full recovery or are you still troubled by symptoms?		<input type="checkbox"/> Symptoms persist	<input type="checkbox"/> Full Recovery
2. Are you more breathless now than you were before your COVID illness?	<input type="checkbox"/> Is this more than you would have expected by now? OR <input type="checkbox"/> Do you think you are on your way back to full fitness?		
3. Do you feel fatigued (worn out/lacking energy or zest) compared with how you were before your COVID illness?	<input type="checkbox"/> Is this more than you would have expected by now? OR <input type="checkbox"/> Do you think you are well on your way back to full fitness?		
4. Do you have a cough (different from any cough you may have had before COVID19)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Do you get any palpitations? (sense that you can feel your heart pounding or racing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. How is your physical strength? Do you feel so weak that it still limiting what you can do (more than you were pre your COVID illness)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Do you have any myalgia ('aching in your muscles')?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Do you have anosmia ('no sense of smell')?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Have you lost your sense of taste?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Is your sleep disturbed (more than it was pre-COVID)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Have you had any nightmares or flashbacks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12. On your mood, is your mood low/do you feel down in the dumps/lacking in motivation/no pleasure in anything?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12b. Do you find yourself feeling anxious/worrying more than you used to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13. Have you lost weight (more than ½ stone, 3 Kg) since your COVID illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
14. Any other symptoms (list): Click here to enter text.			