NCL Primary Care COVID-19 Recovery Questionnaire

Full Name:		**DOB:**	
NHS No:		**Gender:**	
Address:		**Emis no:**	
Telephone:		**Email:**	
Language:		**Ethnicity:**	

You have received this questionnaire because you have an upcoming appointment with your GP to talk about your ongoing symptoms of COVID-19. Before the appointment, please complete this symptom questionnaire. It will help your GP plan your care more effectively and track your progress. If you have difficulty with any of the questions please leave them blank and the clinician will review them with you during your consultation. Thank you.

COVID-19 overview

What date did your initial infection with COVID-19 start? Click or tap to enter a date.

Where did you receive care for COVID-19?

- ☐ I stayed at home
- ☐ I attended A&E department
- ☐ I was admitted to hospital

What were your COVID-19 test results?

Please select multiple options if needed

- ☐ I had a positive swab test
- ☐ I had a positive antibody test
- ☐ I was not tested for COVID-19

Your COVID-19 symptoms

What symptoms did you have in the first two weeks of COVID-19 infection?

Please tick as many as apply

- ☐ None
- ☐ Fever
- ☐ Cough
- ☐ Breathlessness
- ☐ Fatigue
- ☐ Chest pain
- ☐ Chest tightness
- ☐ Palpitations
- ☐ Dizziness
- ☐ Vertigo
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Headache
- ☐ Loss of smell or taste
- ☐ Sore throat
- ☐ Pain in abdomen
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Vomiting / nausea
- ☐ Seizures
- ☐ Leg or arm weakness / tingling
- ☐ Poor sleep
- ☐ Brain fog or problems with memory / concentrating
- ☐ Changes in menstrual cycle in women

Other symptoms (please state)

Click or tap here to enter text.

What symptoms have you experienced in the last two weeks?
Please tick as many as apply

- ☐ Fever
- ☐ Cough
- ☐ Breathlessness
- ☐ Fatigue
- ☐ Chest pain
- ☐ Chest tightness
- ☐ Palpitations
- ☐ Dizziness
- ☐ Vertigo
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Headache
- ☐ Loss of smell or taste
- ☐ Sore throat
- ☐ Pain in abdomen
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Vomiting / nausea
- ☐ Seizures
- ☐ Leg or arm weakness / tingling
- ☐ Poor sleep
- ☐ Brain fog or problems with memory / concentrating
- ☐ Changes in menstrual cycle in women

Other symptoms (please state)
Click or tap here to enter text.

Your overall wellbeing

Do you still feel unwell? ☐ Yes ☐ No

What percentage of your usual health (before COVID-19) do you feel?
Please choose a number between 0-100% Click or tap here to enter text

Are you well enough to work?

- ☐ Yes, full Time
- ☐ Yes, Part time
- ☐ I am not well enough to work
- ☐ I am retired
- ☐ I am unemployed at present

Do you feel your symptoms are improving?

- ☐ Week by week
- ☐ Month by month
- ☐ Up and Down
- ☐ Not at all

Your mental health

Many patients have felt anxious or low as a result of their illness and due to the stress caused by the pandemic. Please complete **both** the questionnaires below

Patient Health Questionnaire (PHQ-9)

Over the *last two weeks*, how often have you been bothered by any of the following problems?

Score	0	1	2	3
Little interest or pleasure in doing things?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Feeling down, depressed, or hopeless?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Trouble falling or staying asleep, or sleeping too much?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Feeling tired or having little energy?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Poor appetite or overeating?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Moving/speaking so slowly or being fidgety/restless?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day

*** PHQ9 Please total up the score: /27**

Generalised Anxiety Disorder Questionnaire (GAD-7)

Over the *last two weeks*, how often have you been bothered by any of the following problems?

Score	0	1	2	3
Feeling nervous, anxious, on edge?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Not being able to stop or control worrying?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Worrying too much about different things?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Trouble relaxing?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Being so restless that it is hard to sit still?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Becoming easily annoyed or irritable?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day
Feeling afraid as if something awful might happen?	☐ Not at all	☐ Several days	☐ > half the days	☐ Nearly every day

*** GAD7 Please total up the score: /21**

Fatigue (using Fatigue assessment scale tool)

The following statements refer to how you usually feel. Per statement you can choose out of one of five answer categories, varying from Never to Always. Please give an answer to each question, even if you have no complaints at the moment.

1 - Never
2 - Sometimes (about monthly or less)
3 - Regularly (about a few times a month)
4 - Often (about weekly)
5 - Always (about every day)

Score	1	2	3	4	5
I am bothered by fatigue	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
I get tired very quickly	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
I don't do much during the day	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
I have enough energy for everyday life	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
Physically I feel exhausted	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
I have problems to start things	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
I have problems to think clearly	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
I feel no desire to do anything	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
Mentally, I feel exhausted	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always
When I am doing something, I can concentrate quite well	☐ Never	☐ Sometimes	☐ Regularly	☐ Often	☐ Always

*** Please total up the score: /50**

Breathlessness

Please rate your experience of breathlessness using the scales below. The first is before you had COVID-19, the second is how you feel now:

Which of the following best describes your experience of breathlessness before you had COVID-19?

☐ I am not troubled by breathlessness unless I exercise strenuously.
☐ I am breathless when hurrying on level ground or going up inclines.
☐ I am breathless within 15 minutes on level ground or within 11 metres.
☐ I am too breathless to leave the house, or breathless getting dressed or undressed.

Which of the following best describes your experience of breathlessness before you had COVID-19?

☐ I am not troubled by breathlessness unless I exercise strenuously.
☐ I am breathless when hurrying on level ground or going up inclines.
☐ I am breathless within 15 minutes on level ground or within 11 metres.
☐ I am too breathless to leave the house, or breathless getting dressed or undressed.

Your quality of life

Please answer the following questions about you feel today.

Mobility

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walkabout

Self-care

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing/dressing myself
- ☐ I have severe problems washing/dressing myself
- ☐ I am unable to wash or dress myself.

Usual activities

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

Pain / Discomfort

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety / depression

- ☐ I am not anxious or depressed
- ☐ I have slight anxious or depressed
- ☐ I have moderate anxious or depressed
- ☐ I have severe anxious or depressed
- ☐ I have extremely anxious or depressed

On a scale of 1 to 100 (where 1 is the worst health you can imagine and 100 is the best health you can imagine) – we would like you know how good to bad your health is *today*.

Click or tap here to enter text

Being active

Please answer these questions about how you feel after being active.

Do you feel worse after being active? ☐ Yes ☐ No

If you answer yes to the previous question, how long do you feel worse after activity?

☐ <1 hour ☐ 2-3 hours ☐ 4-12 hours ☐ 13-24 hours ☐ >24 hours

What matters to you?

Overall, what is most important to you in terms of your COVID-19 recovery?

Click or tap here to enter text.

Is there anything else you would like to share with your GP about your COVID-19 recovery before your consultation?

Click or tap here to enter text.

Thank you for completing this questionnaire.