Your name: **date:**

1. Have you made a full recovery or are you still troubled by symptoms?	☐Symptoms persist	☐Full Recovery
2. Are you more breathless now than you were before your COVID illness?	☐ Is this more than you would have expected by now? OR ☐ 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?	☐ Is this more than you would have expected by now? OR ☐ 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)?	☐ Yes	☐ No
5. Do you get any palpitations? (sense that you can feel your heart pounding or racing)	☐ Yes	☐ 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)?	☐ Yes	☐ No
7. Do you have any myalgia ('aching in your muscles')?	☐ Yes	☐ No
8. Do you have anosmia ('no sense of smell')?	☐ Yes	☐ No
9. Have you lost your sense of taste?	☐ Yes	☐ No
10. Is your sleep disturbed (more than it was pre-COVID)?	☐ Yes	☐ No
11. Have you had any nightmares or flashbacks?	☐ Yes	☐ No
12. On your mood, is your mood low/do you feel down in the dumps/lacking in motivation/no pleasure in anything?	☐ Yes	☐ No
12b. Do you find yourself feeling anxious/worrying more than you used to?	☐ Yes	☐ No
13. Have you lost weight (more than ½ stone, 3 Kg) since your COVID illness?	☐ Yes	☐ No
14. Any other symptoms (list):		