1. Have you ever been diagnosed with COVID-19?

Yes [☐] No [☐]

If Yes:

a) Approximately when was your diagnosis?

[___________] (date)

b) How was your diagnosis confirmed?

[PCR Test] [Antibody Test] [Antigen (rapid) Test] [Other / unknown]

c) Were you symptomatic?

[Yes] [No]

If yes, which symptoms did you have?

[☐] Cough [☐] Tiredness [☐] Shortness of breath [☐] Fever

[☐] Sore throat [☐] Loss of taste [☐] Loss of sense of smell

[☐] Nausea [☐] Vomiting [☐] Diarrhea

[☐] Chills [☐] Runny nose [☐] Muscle aches

d) Do you have ongoing symptoms ("long-Covid")?

[Yes] [No]

If yes, which symptoms persist?

[☐] Cough [☐] Tiredness [☐] Shortness of breath

[☐] Sore throat [☐] Loss of taste [☐] Loss of sense of smell

[☐] Nausea [☐] Vomiting [☐] Diarrhea

[☐] Chills [☐] Runny nose [☐] Muscle aches

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**COVID-19 Vaccination Status**

1. Have you been administered a vaccine for COVID-19?

Yes [☐] No [☐]

If Yes:

a) Which vaccine were you administered (if known)?


[☐] Other / unknown

b) How many doses have you received?

One [☐] Two [☐]

c) When was the (approximate) date of the 1st dose?

[___________] (date)

and the 2nd dose?

[___________] (date)