REACT-LCS survey: Health and wellbeing during the pandemic

Stage 3: Batches 11 - 15

Contents

LANDING PAGE

This is the REACT-LCS Health and Wellbeing survey.

Please enter your 8 character access code from your invitation email. Please enter the first four digits in the first box and the last four digits in the second box.

(Free text, 8 characters using a box of four characters and a second box of four characters.

Text box for information: If you did not receive an email to take part in this study, thank you for being so keen to help, but our studies are currently invitation only.

SECTION 1: PARTICIPANT CONFIRMATION AND CONSENT

Introductory screen

This survey is part of an extension study to the REal-time Assessment of Community Transmission (REACT) study being led by Imperial College London. The main aim is to better understand the health and wellbeing experiences of the public over the course of the COVID pandemic.

If you would like to read the study's participant information booklet you can access it at

https://www.imperial.ac.uk/medicine/research-and-impact/groups/react-study/studies/react-long-covid/

This explains the purpose of the research, what it will involve and how the data you provide is used among other information about the study.

Before we begin, we would like to inform you that Ipsos is a member of the Market Research Society.

Taking part is voluntary and you can change your mind at any time.

ASK ALL

INDCONF

This survey is for [FF_Surname] [FF_Surname]. Are you [FF_Surname] [FF_Surname]?

Please select one answer

1. Yes
2. No

IF INDCONF=2

INDCONFCARER

This survey is intended for [FF_firstame] [FF_Surname]. If you are a carer for [FF_firstname] [FF_Surname], or they need assistance, you can help them to complete the survey. Are you a carer for [FF_firstname] [FF_Surname], or assisting them?

1. Yes
2. No

IF INDCONFCARER = 2

CLOSE1

"We thank you for your time spent taking this survey."

TERMINATE

CONSENT

You have been invited to join this study because you took part in the REACT study. If you feel uncomfortable about answering a question, you do not have to answer that question. All the information we collect will be kept private and confidential. The information gathered during this research will be used for research purposes only. Taking part is voluntary and you can change your mind at any time.

If you consent to take part in the research, your name or other identifying information will not be shared outside the research team. Your personal data will never be available to the general public in any circumstances.

Further information is available in the participant information booklet, you can access it at

https://www.imperial.ac.uk/medicine/research-and-impact/groups/react-study/studies/react-long-covid/

Do you agree to take part in this study by completing this questionnaire?

1. Yes
2. No

SECTION 2: CURRENT HEALTH, SYMPTOMS AND IMPACTS

The following questions will help us understand more about your health and if you suffer from any health conditions.

ASK ALL

HEALTH

How is your health in general? Is it…

1. Very Good
2. Good
3. Fair
4. Bad
5. Very bad
6. Prefer not to say

OVERALL SYMPTOM QUESTION

ASK ALL

SYMPTANY1

In the last two weeks, that is since <DAY/MONTH>, have you experienced any of the following symptoms?

Please include **any** symptom you have experienced over the last two weeks, including those that have resolved or lasted only a few days.

Please select all that apply.

1. Fever
2. Persistent cough
3. Shortness of breath (compare with what's normal for you)
4. Chest pain/tightness
5. Headache
6. Dizziness
7. Mild fatigue (e.g. feeling more tired than normal)
8. Severe fatigue (e.g. inability to get out of bed)
9. Loss of appetite (skipping meals)
10. Joint pain/Aches
11. Muscle pain/Aches
12. Difficulty thinking or concentrating ("brain fog")
13. Fast pulse or irregular heartbeat / heart palpitations
14. None of these – FIXED CODE (EXCLUSIVE)
15. Prefer not to say – FIXED CODE (EXCLUSIVE)

ASK ALL

SYMPTANY2

[ROTATE LIST. KEEP CODES 7 AND 8 TOGETHER, CODES 14, 15 AND 16 TOGETHER]

How about these? Have you experienced any of the following in the last two weeks, that is since <DAY/MONTH>?

Please include **any** symptom you have experienced over the last two weeks, including those that have resolved or lasted only a few days.

Please select all that apply.

1. Leg swelling (including due to thrombosis)
2. Sudden swelling of face or lips
3. Red or purples sores/blisters on your feet (including toes)
4. Numbness or tingling somewhere in the body
5. Skin issues (itchy, scaly, redness, rash)
6. Itchy eyes
7. Loss or change to sense of taste
8. Loss or change to sense of smell
9. Vision issues
10. Ringing in the ears (tinnitus)
11. Hair loss
12. Difficulty sleeping
13. Poor memory

14. Mood swings
15. Anxiety
16. Low mood
17. Other (please write in) *(Free text box max 200 characters)* – FIXED CODE
18. None of these– FIXED CODE (EXCLUSIVE)
19. Prefer not to say – FIXED CODE (EXCLUSIVE)

ASK IF CODES 1 TO 13 SELECTED AT SYMPTANY1 OR CODES 1 TO 17 SELECTED AT SYMPTANY2

SYMPTSTART

MULTICODE

Which symptom(s), if any, started after 1 January 2020?

[DISPLAY LIST OF SYMPTOMS SELECTED AT SYMPTANY1 OR SYMPTANY2 SO THEY CAN BE SELECTED]

None of these

☑
Prefer not to say

DATESYMPTSTART

Thinking about < each symptom selected at SYMPTSTART>, when did this symptom start?

If this is something you experience occasionally, please tell us when you first started to experience this symptom.

If you can't remember exactly when, please enter your best guess.

MONTH/YEAR

1. Don't know

ALL SYMPTOMS SELECTED AT SYMPTANY1 or SYMPTANY2. DISPLAY EACH SYSTEM AT A TIME.

CURRENTSYMPT

Thinking about <symptom selected at SYMPTANY1 or SYMPTANY2 >, are you currently experiencing this symptom?

If this is something you experience occasionally, please answer "yes".

1. Yes
2. No – This symptom has finished

ASK IF CURRENTSYMPT = 1

FREQSYMPT

Still thinking about <symptom selected at SYMPTANY1 or SYMPTANY2>,

How often in the last two weeks, that is since <DATE/MONTH>, have you experienced this symptom?

1. Every day in the last two weeks
2. Most days in the last two weeks
3. Only once in the last two weeks
4. Occasionally in the last two weeks
5. Don't know

ASK IF CODES 1 TO 13 SELECTED AT SYMPTANY1 OR CODES 1 TO 17 SELECTED AT SYMPTANY2

LONGCOVIDABILITY

How much, if at all, did your symptoms reduce your ability to carry out day-to-day activities?

1. A lot
2. A little
3. Not at all
4. Don't know
5. Prefer not to say

ASK IF CODES 1 TO 13 SELECTED AT SYMPTANY1 OR CODES 1 TO 17 SELECTED AT SYMPTANY2

LONGCOVIDMED

In the last two weeks, that is since <DATE/MONTH>,have you accessed any medical help for your symptoms from any of the following?

Please select all that apply.

1. Contacted NHS 111, by phone or online
2. Visited pharmacist
3. Consulted GP/practice nurse over the phone or online
4. Consulted GP/practice nurse face to face
5. Walk-in centre
6. Accident and Emergency (A&E)
7. Hospital appointment or consultation (outpatient)
8. Hospital admission
9. Hospital admission: intensive care unit
10. Long COVID clinic
11. Other, please write in ……. [free text]
12. No, did not seek medical attention
13. No, tried to seek medical attention but could not get access to medical help

BREATHING

ASK ALL

MRC1

Does the following apply to you?

Not troubled by breathlessness except on strenuous exercise.

1. Yes - I am not troubled by breathlessness
2. No

ASK IF MRC1=2

MRC2

Does the following apply to you?

Short of breath when hurrying on a level or when walking up a slight hill.

1. Yes
2. No

ASK IF MRC2=1

MRC3

Does the following apply to you?

Walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace.

1. Yes
2. No

ASK IF MRC3=1

MRC4

Does the following apply to you?

Stops for breath after walking 100 yards, or after a few minutes on level ground.

1. Yes
2. No

ASK IF MRC4=1

MRC5

Does the following apply to you?

Too breathless to leave the house, or breathless when dressing/undressing.

1. Yes
2. No

NEWSOB2 Please read each statement and then select the answer that best matches your breathing these days.

ASK IF SYMPTANY1=3 (Shortness of breath (compare with what's normal for you)

NEWSOB2.1
My breath does not go in all the way

1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.2
My breathing requires work

1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.3
I feel short of breath

1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.4
I have difficulty catching my breath

1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.5
I cannot get enough air

1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.6
My breathing is uncomfortable

1. None
2. Mild
3. Moderate

4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.7
My breathing is exhausting
1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.8
My breathing makes me feel depressed
1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.9
My breathing makes me feel miserable
1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.10
My breathing is distressing
1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.11
My breathing makes me feel agitated
1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

NEWSOB2.12
My breathing is irritating

1. None
2. Mild
3. Moderate
4. Severe
5. Don't know
6. Prefer not to say

ASK IF SYMPTANY1 = 7 OR 8 (Mild fatigue (e.g. feeling more tired than normal) Severe fatigue (e.g. inability to get out of bed)

POSTACTIVE2
Do you experience a worsening of your fatigue/energy related symptoms after engaging in minimal physical effort?

1. Yes
2. No
3. Don't know

POSTACTIVE3
Do you experience a worsening of your fatigue/energy related symptoms after engaging in mental effort?

1. Yes
2. No
3. Don't know

POSTACTIVE4
If you feel worse after activities, how long does this last?

1. Under 1 hour
2. 2 to 3 hours
3. 4 to 10 hours
4. 11 to 13 hours
5. 14 to 23 hours
6. 24 hours or over
7. Don't know
8. Not applicable

POSTACTIVE5
Does exercise make your fatigue/energy related symptoms worse?

1. Yes
2. No
3. Don't know

HEALTH IMPACTS

EQ-5D-5L – Health Questionnaire – EuroQol questions. See the demo and guidelines for scripting.

Please select the ONE box that best describes your health TODAY

MOBILITY

MOBILITY

1. I have no problems in walking about
2. I have slight problems in walking about
3. I have moderate problems in walking about
4. I have severe problems in walking about
5. I am unable to walk about

SELFCARE

SELF-CARE

1. I have no problems washing or dressing myself
2. I have slight problems washing or dressing myself
3. I have moderate problems washing or dressing myself
4. I have severe problems washing or dressing myself
5. I am unable to wash or dress myself

ACTIVITIES

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

1. I have no problems doing my usual activities
2. I have slight problems doing my usual activities
3. I have moderate problems doing my usual activities
4. I have severe problems doing my usual activities
5. I am unable to do my usual activities

PAINDISC

PAIN/DISCOMFORT

1. I have no pain or discomfort
2. I have slight pain or discomfort
3. I have moderate pain or discomfort
4. I have severe pain or discomfort
5. I have extreme pain or discomfort

ANXIETYDEP

ANXIETY/DEPRESSION

1. I am not anxious or depressed
2. I am slightly anxious or depressed
3. I am moderately anxious or depressed
4. I am severely anxious or depressed
5. I am extremely anxious or depressed

HEALTHSCORE

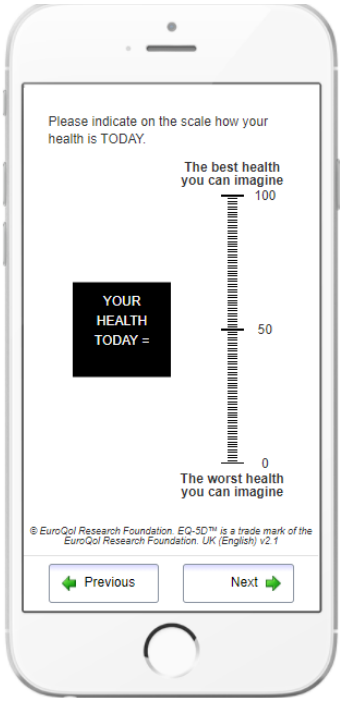
We would like to know how good or bad your health is TODAY.

You will see a scale numbered from 0 to 100.

100 means the best health you can imagine.

0 means the worst health you can imagine.

Please indicate on the scale how your health is TODAY



SECTION 3: COVID-19 VACCINATION STATUS AND HISTORY OF INFECTION

VACCINATION STATUS

ASK ALL

VACCINE3

Have you ever received a vaccine(s) for the coronavirus (COVID-19)?

1. Yes

2. No

3. Don't know

4. Prefer not to say

IF VACCINE3 = 1

VACCDOSE

Most of the vaccines require more than one dose which are given as separate injections some time apart.

How many doses (injections) have you had so far?

1. One

2. Two

3. Three

4. More than three

COVID HISTORY

ASK ALL

HADCOVID

Do you think you have or have ever had the coronavirus (COVID-19)?

1. Yes
2. No
   3.Don't know

IF HADCOVID = 1

HADCOVIDTIMES

Do you think you have had COVID-19 more than once?

1. Yes
2. Not sure
3. No
4. Prefer not to say

First COVID-19 infection

IF **HADCOVID = 1**

COVIDNUM How many times do you think you have had COVID-19?

[NUMBER]

IF HADCOVID = 1 AND HADCOVIDTIMES = 2,3,4 "THE TIME

COVIDA

Thinking about the [IF HADCOVID = 1 AND HADCOVIDTIMES= 2,3 OR 4 <time>, IF < HADCOVID = 1 AND HADCOVIDTIMES =1<first time>] you had COVID-19, was it.....

1. Confirmed by a positive test (swab/PCR/antigen test/lateral flow swab test) (A swab/PCR/antigen test/lateral flow swab test is done by a nasal or throat swab and tests for current COVID-19 infection)
2. Suspected by a doctor but not tested
3. My own suspicions

IF COVIDA = 1

COVIDB1

When did you take the first test (swab/PCR/antigen test/lateral flow swab test) which came back positive for the [IF HADCOVID 1 AND HADCOVIDTIMES= 2,3 OR 4 < time>, IF < HADCOVID = 1 AND HADCOVIDTIMES =1<first time>] you had COVID-19? If you have taken different types of tests, please tell us the date of the first test you took.

Please try to be as accurate as possible.

[DO NOT ALLOW DATE BEFORE JANUARY 2020]

MONTH/YEAR

IF COVIDA = 1, 2 OR 3

COVIDC1

How severe was your illness when you {IF COVIDA=1 had; IF COVIDA=2 or 3 thought you had} COVID-19 IF < HADCOVID = 1 AND HADCOVIDTIMES =1<the first time>]?

1. No symptoms
2. Mild symptoms – didn't affect my daily life
3. Moderate symptoms – some effect on my daily life
4. Severe symptoms – significant effect on my daily life

IF COVIDC1 = 2, 3 or 4

COVIDD1

What kind of medical attention, if any, did you access for your illness when you {IF COVIDA=1 had; IF COVIDA=2 or 3 thought you had} COVID-19< HADCOVID = 1 AND HADCOVIDTIMES =1<the first time>?

Please select all that apply.

1. Contacted NHS 111, by phone or online
2. Visited pharmacist
3. Consulted GP/practice nurse over the phone or online
4. Consulted GP/practice nurse face to face
5. Walk-in centre
6. Accident and Emergency
7. Hospital admission
8. Hospital admission: intensive care unit
9. Other, please write in……. [free text]
10. None

IF COVIDC1 = 2, 3 or 4

COVIDSTA1

When did your first symptoms start when you had COVID-19 IF < HADCOVID = 1 AND HADCOVIDTIMES =1<the first time> (as best as you can remember)?

[DO NOT ALLOW DATE BEFORE JANUARY 2020]

DAY/MONTH/YEAR

IF COVIDC1 = 2, 3 or 4

COVIDEND1

When did your symptoms finish when you had COVID-19 [IF < HADCOVID = 1 AND HADCOVIDTIMES =1<the first time>] (as best as you can remember)?

[DO NOT ALLOW DATE BEFORE JANUARY 2020]

DAY/MONTH/YEAR

1. I still have symptoms

IF COVIDC1 = 2, 3 or 4

COVIDSYM1

[Which of the following symptoms were part of your COVID-19 illness [IF < HADCOVID = 1 AND HADCOVIDTIMES =1<the first time you had COVID-19>]?

Please select all the symptoms you had, whether or not you saw a doctor.

1. Decrease in appetite
2. Nausea and/or vomiting
3. Diarrhoea
4. Abdominal pain/tummy ache
5. Runny nose
6. Sneezing
7. Blocked nose
8. Sore eyes

9. Loss or change to sense of smell
10. Loss or change to sense of taste
11. Sore throat
12. Hoarse voice
13. Headache
14. Dizziness
15. None of these – FIXED CODE (EXCLUSIVE)
16. Prefer not to say – FIXED CODE (EXCLUSIVE)

COVIDSYM2

Which of the following symptoms were part of your COVID-19 illness [IF < HADCOVID = 1 AND HADCOVIDTIMES =1<the first time you had COVID-19>]?

Please select all the symptoms you had, whether or not you saw a doctor.

1. Shortness of breath affecting normal activities
2. New persistent cough
3. Tightness in chest
4. Chest pain
5. Fever (feeling too hot)
6. Chills (feeling too cold)
7. Difficulty sleeping
8. Felt more tired than normal
9. Severe fatigue (e.g. inability to get out of bed)
10. Numbness or tingling somewhere in the body
11. Feeling of heaviness in arms or legs
12. Achy muscles
13. Raised, red, itchy areas on the skin
14. Sudden swelling of the face or lips
15. Red/purple sores or blisters on your feet (including toes)
16. Leg swelling (Thrombosis)
17. Other symptom (please write in)
18. None of these – FIXED CODE (EXCLUSIVE)
19. Prefer not to say – FIXED CODE (EXCLUSIVE)

Most recent COVID-19 infection

IF HADCOVID = 1 AND HADCOVIDTIMES = 1: “THE MOST RECENT TIME”

COVIDA2

Thinking about the most recent time thought you had COVID-19, was it....

1. Confirmed by a positive test (swab/PCR/antigen test/ lateral flow swab test) INFO BUTTON: (A swab/PCR/antigen test/lateral flow swab test is done by a nasal or throat swab and tests for current COVID-19 infection)
2. Suspected by a doctor but not tested
3. My own suspicions

IF COVIDA**2** = 1

COVIDB2

When did you take the first test (swab/PCR/antigen test/lateral flow swab test) which came back positive for the most recent time you had COVID-19 ? If you have taken different types of tests, please tell us the date of the first test you took for your most recent COVID-19 episode.

Please try to be as accurate as possible.

MONTH/YEAR

IF COVIDA2 = 1, 2 OR 3

COVIDC2

How severe was your illness when you {IF COVIDA2=1 had; IF COVIDA2=2 or 3 thought you had} COVID-19 the most recent time?

1. No symptoms
2. Mild symptoms – didn't affect my daily life
3. Moderate symptoms – some effect on my daily life
4. Severe symptoms – significant effect on my daily life

IF COVIDC2 = 2, 3 or 4

COVIDD2

What kind of medical attention, if any, did you access for your illness when you {IF COVIDA2=1 had; IF COVIDA2=2 or 3 thought you had} COVID-19 the most recent time?

Please select all that apply.

1. None
2. Contacted NHS 111, by phone or online
3. Visited pharmacist
4. Consulted GP/practice nurse over the phone or online
5. Consulted GP/practice nurse face to face
6. Walk-in centre
7. Accident and Emergency
8. Hospital admission
9. Hospital admission: intensive care unit
10. Other, please write in ……. [free text]

IF COVIDC2 = 2, 3 or 4

COVIDSTA2

When did your first symptoms start when you had COVID-19 the most recent time (as best as you can remember)?

[DO NOT ALLOW DATE BEFORE JANUARY 2020]

DAY/MONTH/YEAR

IF COVIDC2 = 2, 3 or 4

COVIDEND2

When did your symptoms finish when you had COVID-19 the most recent time (as best as you can remember)?

[DO NOT ALLOW DATE BEFORE JANUARY 2020]

DAY/MONTH/YEAR

1. I still have symptoms

IF COVIDC2 = 2, 3 or 4

COVIDSYM3

Which of the following symptoms were part of your COVID-19 illness the most recent time you had COVID-19?

Please select all the symptoms you had, whether or not you saw a doctor.

1. Decrease in appetite
2. Nausea and/or vomiting
3. Diarrhoea
4. Abdominal pain/tummy ache
5. Runny nose
6. Sneezing
7. Blocked nose
8. Sore eyes
9. Loss or change to sense of smell
10. Loss or change to sense of taste
11. Sore throat
12. Hoarse voice
13. Headache
14. Dizziness
17. None of these – FIXED CODE (EXCLUSIVE)
18. Prefer not to say – FIXED CODE (EXCLUSIVE)

COVIDSYM4

Which of the following symptoms were part of your COVID-19 illness the most recent time you had COVID-19?

Please select all the symptoms you had, whether or not you saw a doctor.

1. Shortness of breath affecting normal activities
2. New persistent cough
3. Tightness in chest
4. Chest pain
5. Fever (feeling too hot)

6. Chills (feeling too cold)
7. Difficulty sleeping
8. Felt more tired than normal
9. Severe fatigue (e.g. inability to get out of bed)
10. Numbness or tingling somewhere in the body
11. Feeling of heaviness in arms or legs
12. Achy muscles
13. Raised, red, itchy areas on the skin
14. Sudden swelling of the face or lips
15. Red/purple sores or blisters on your feet (including toes)
16. Leg swelling (Thrombosis)
17. Other symptom (please write in) [free text] – FIXED CODE
18. None of these – FIXED CODE (EXCLUSIVE)
19. Prefer not to say – FIXED CODE (EXCLUSIVE

COVIDC1 = 2,3 OR 4 or COVIDC2 = 2, 3 OR 4

SYMDURATION

Thinking about [IF < HADCOVID = 1 AND HADCOVIDTIMES =1 all the times you had] [HADCOVID = 1 AND HADCOVIDTIMES =2, 3 OR 4 the time you had] COVID-19, did any of your symptoms last more than 12 weeks?

1. Yes
2. No
3. Don't know

IF SYMPDURATION =1

PERSISTSYM1

Please indicate which, if any, persistent symptoms (lasting more than 12 weeks) you think may be linked to you having had COVID-19?

Please select all that apply.

1. Fever
2. Persistent cough
3. Shortness of breath (compare with what's normal for you)
4. Chest pain/tightness
5. Headache
6. Dizziness
7. Mild fatigue (e.g. feeling more tired than normal)
8. Severe fatigue (e.g. inability to get out of bed)
9. Loss of appetite (skipping meals)
10. Joint pain/Aches
11. Muscle pain/Aches
12. Difficulty thinking or concentrating ("brain fog")
13. Fast pulse or irregular heartbeat / heart palpitations
14. None of these– FIXED CODE (EXCLUSIVE)

15. Prefer not to say – FIXED CODE (EXCLUSIVE)

PERSISTSYM2

How about these?

Please select all that apply.

1. Leg swelling (including due to thrombosis)
2. Sudden swelling of face or lips
3. Red or purples sores/blisters on your feet (including toes)
4. Numbness or tingling somewhere in the body
5. Skin issues (itchy, scaly, redness, rash)
6. Itchy eyes
7. Loss or change to sense of taste
8. Loss or change to send of smell
9. Vision issues
10. Ringing in the ears (tinnitus)
11. Hair loss
12. Difficulty sleeping
13. Poor memory
14. Mood swings
15. Anxiety
16. Low mood
17. Other (please write in) *(Free text box max 200 characters)* – FIXED CODE
18. None of these– FIXED CODE (EXCLUSIVE)
19. Prefer not to say – FIXED CODE (EXCLUSIVE)

IF HADCOVID=1

CONDITION

Have you experienced a new health condition, illness or disability lasting for more than 12 weeks you think may be linked to you having had COVID-19? Please also think about and include the ones that have now resolved.

1. Yes
2. Unsure
3. No
4. Prefer not to say

PERSISTDIAG1

Were you diagnosed by a healthcare professional with persistent symptoms (lasting more than 12 weeks), or a new health condition, illness or disability lasting more than 12 weeks that your doctor thought was linked to you having had COVID-19?

Please also think about and include the ones that have now resolved.

1. Yes
2. Unsure
3. No
4. Prefer not to say

IF PERSISTDIAG1 =1

PERSISTDIAG2

Please indicate which persistent symptoms (lasting more than 12 weeks), your doctor has linked to you having had COVID-19?

Please select all that apply.

<LIST SYMPTOMS SELECTED AT COVIDSYM1 AND COVIDSYM2 AND COVIDSYM3 AND COVIDSYM4>

1. None of these
2. Prefer not to say

IF PERSISTDIAG1 =1

HEALTHCOND

Please indicate what new health condition, illness or disability lasting for more than 12 weeks your doctor has linked to you having had COVID-19.

Please select all that apply.

1. Post-viral fatigue
2. Long Covid
3. A blood clot (e.g. in the leg, lung, heart or brain)
4. A heart condition
5. A lung condition
6. A condition affecting the brain
7. A condition affecting the nervous system outside the brain (e.g. Guillain Barre)
8. A condition affecting the kidneys
9. Thyroid disease
10. A mental health condition
11. A condition that causes joint and/or muscle pain
12. An autoimmune condition
13. Gastrointestinal condition
14. Skin conditions
15. Reproductive condition
16. ENT (Ear nose and throat) conditions
17. Eye or vision conditions
18. Other – please write in [Free text] – FIXED CODE
19. None of these
20. Prefer not to say

IF HADCOVID =1

COVRECOV

Do you feel fully recovered from COVID-19?

1. Yes
2. No
3. Not sure

IF SYMDURATION = 1 OR CONDITION =1

TREATMENT1

Please tell us about anything you have tried doing which you think has, or may have, helped you overcome lasting symptoms of COVID-19.

Please do not include treatments prescribed by a healthcare professional or treatments prescribed in a healthcare clinic (for example a Long COVID clinic).

1. I have not tried anything which has helped
2. Prefer not to say

<OPEN TEXT>

TREATMENT2

Please tell us about which, if any, PRESCRIBED TREATMENTS you have had for lasting symptoms of COVID-19 and whether they have helped.

Please only include treatments which were prescribed by a healthcare professional or treatments prescribed in a healthcare clinic (for example a Long COVID clinic).

<OPEN TEXT>

1. A healthcare professional did not prescribe any treatments
2. Prefer not to say

TREATMENT3

Please tell us about anything you may have done which you think hasmade your symptoms of COVID-19 worse.

<OPEN TEXT>

1. I have not done anything which has made it worse
2. Prefer not to say

IF (SYMPTANY1=2 (persistent cough) OR SYMPTANY1=3 (Shortness of breath)) OR (PERSISTSYM1=2 (persistent cough) OR PERSISTYM1=3 (shortness of breath)) OR IF COVIDSYM2 = 1(shortness of breath) OR COVIDSYM2 = 2(persistent cough) OR COVIDSYM4=1 (shortness of breath) OR COVIDSYM4 = 2(persistent cough).

CONSULT

You told us that you have had

([SYMPTANY1=3 OR PERSISTYM1=3 OR COVIDSYM2 =1 OR COVIDSYM4=1] shortness of breath.)

([SYMPTANY1=2 OR PERSISTSYM1=2 OR COVIDSYM2 = 2 OR COVIDSYM4 = 2] a persistent cough.)

[(SYMPTANY1=3 OR PERSISTYM1=3 OR COVIDSYM2 =1 OR COVIDSYM4=1) AND (SYMPTANY1=2 OR PERSISTSYM1=2 OR COVIDSYM2 = 2 OR COVIDSYM4 = 2)] both shortness of breath and a persistent cough.)

Have you consulted a healthcare professional (e.g. Nurse, GP, or Hospital specialists) about this?

Please select one answer.

1. Yes
2. No

IF CONSULT=1

CONSULTEST

Did the healthcare professional refer you for any of the following tests?

Please select all that apply.

1. Blood tests
2. Breathing Tests/Lung function
3. Chest X Ray
4. Chest CT scan
5. None [Exclusive]
6. Don’t know [Exclusive]

IF CONSULTEST = 4

SCANRESULT

As far as you know, which of these best describes the result of the chest CT scan?

1. Normal
2. Abnormal
3. Don’t know [Exclusive]

IF SCANRESULT=2

SCANDIAG

Were you diagnosed with any of the following after the chest CT scan?

Please select all that apply.

1. Asthma
2. Chronic Obstructive Airways Disease (COPD)/Chronic bronchitis
3. Pneumonia
4. Tuberculosis (TB)
5. Interstitial Lung Disease (ILD)
6. Bronchiectasis
7. Pulmonary Fibrosis
8. Other (please specify)
9. Don't Know [Exclusive]

SECTION 4: MEDICAL HISTORY

ASK ALL

GENDER

Which of the following best describes you?

1. Female
2. Male
3. Non-binary
4. Prefer to self-describe, please write in [free text] – FIXED
5. Prefer not to say

GENDIDENT

Is your gender identity the same as the sex you were registered at birth?

1. Yes
2. No
3. Prefer not to say

ASK ALL

WEIGHT

What is your current weight? If you are unsure please give an estimate.

{Default box is stones and pounds but with button to click to get kg}

STONES (NUMBER RANGE 3 to 40) POUNDS (NUMBER RANGE 0 to 13)

WEIGHT CHECK WORDING IF POUNDS MISSING: Missing Answer: Please enter a value for stones AND pounds. If your weight is an exact number of stones please enter 0 in the pounds box.

WEIGHT CHECK WORDING ANSWER OUTSIDE VALID RANGE: Your answer is not within the range for this question. Please enter an answer between 3 stone 0 pounds and 40 stone 0 pounds. There are 14 pounds in a stone.

KILOGRAMS (NUMBER RANGE 20 to 250)

3. Cannot give estimate

4. Prefer not to say

ASK ALL

WGTCHK

Your weight is [^insert stones^] and [^insert pounds^] / [^insert kgs^], is that correct?

1. Yes

2. No - you will be taken back to change your answer (RETURN TO WEIGHT)

ASK ALL

CONDHIST1

Do you have any of the following (or do any of the following apply to you)?

Please select all that apply.

(ROTATE LIST)

1. Organ transplant recipient
2. Diabetes (type I or II)
3. Heart disease or heart problems such as heart failure
4. Hypertension (high blood pressure)
5. Stroke
6. Kidney failure (kidneys do not work well)
7. Liver disease
8. Anaemia
9. Allergy (eczema, hay fever, rhinitis)
10. None of these – FIXED CODE (EXCLUSIVE)
11. Prefer not to say – FIXED CODE (EXCLUSIVE)

ASK ALL

CONDHIST2

How about these? Do you have any of the following (or do any of the following apply to you)?

Please select all that apply.

1. Asthma
2. Other condition affecting lungs (such as chronic obstructive lung disease (COPD), bronchitis or emphysema)
3. Cancer
4. Fibromyalgia

5. Epilepsy
6. Other condition affecting the brain and nerves (e.g. Dementia, Parkinson's, Multiple Sclerosis, Myasthenia Gravis)
7. Osteoarthritis
8. A weakened immune system/reduced ability to deal with infections (as a result of a disease or treatment)
9. Hepatitis, tuberculosis or other chronic infection.
10. None of these – FIXED CODE (EXCLUSIVE)
11. Prefer not to say – FIXED CODE (EXCLUSIVE)

ASK ALL

CONDHIST3

How about these? Do you have any of the following?

Please select all that apply.

1. Dementia
2. Anxiety
3. Depression
4. Any other psychiatric condition e.g. bipolar disorder, schizophrenia, anorexia or bulimia
5. Rheumatoid arthritis
6. Hypothyroidism (underactive thyroid gland)
7. Hyperthyroidism (overactive thyroid gland)
8. Addison's or Cushing's disease (poor functioning of the adrenal glands)
9. Sleep apnoea/ narcolepsy
10. Any other serious illness
    Please write in: [free text] -_[FIXED CODE]
11. None of these – FIXED CODE (EXCLUSIVE)
12. Prefer not to say – FIXED CODE (EXCLUSIVE)

ASK IF CODE 1 TO 9 AT CONDHIST1 OR CODE 1 TO 9 AT ONDHIST2OR CODE 1 TO 10 AT CONDHIST3

CONDHISTSTART

[IF CONDHIST1 = 2 TO 9, OR CONDHIST2 = 1 TO 9, OR CONDHIST3 = 1 TO 11 Approximately when did each condition start?

If your condition started before January 2020 please select "before January 2020".]

[LOOP EACH CONDITION SELECTED AT CONDHIST1 = 2 TO 9, OR CONDHIST2 = 1 TO 9, OR CONDHIST3 = 1 TO 11]

[IF CONDHIST1 =1 What is the date of the organ transplant?

If your transplant date was before January 2020 please select "before January 2020".]

[DO NOT ALLOW DATE BEFORE JANUARY 2020]

1. MONTH/YEAR

2. Before January 2020 i.e. before the start of the COVID-19 pandemic

3. Prefer not to answer

WOMEN'S HEALTH

ASK IF GENDER =1 AND GENDIDENT =1

Menstruation

We would like to understand whether the pandemic has had an effect on menstruation.

CYCLE1

How long is your menstrual cycle at the moment? This is the number of days between the first day of each menstrual period.

1. Less than 26 days
2. 26-27 days
3. 28 days
4. 29-30 days
5. 31-33 days
6. 34 days or more
7. Not sure (irregular cycles)
8. My periods have stopped
9. I've never had a period
10. Don't know
11. Prefer not to say

CYCLE2

Is your period different now compared to before January 2020 (i.e. before the start of the COVID-19 pandemic)?

1. Yes
2. No
3. Unsure

ASK IF **CYCLE2 = 1**

Please select what changes you have noticed to your period and period related symptoms (e.g. PMS):

CYCHANGE1

Frequency

1. Increased significantly
2. Increased slightly
3. Stayed the same
4. Decreased slightly
5. Decreased Significantly Fluctuates (sometimes increases / sometimes decreases)

CYCHANGE2

Length

1. Increased significantly
2. Increased slightly
3. Stayed the same
4. Decreased slightly
5. Decreased Significantly Fluctuates (sometimes increases / sometimes decreases)

CYCHANGE3

Heaviness

1. Increased significantly
2. Increased slightly
3. Stayed the same
4. Decreased slightly
5. Decreased Significantly Fluctuates (sometimes increases / sometimes decreases)

CYCHANGE4

Pain

1. Increased significantly
2. Increased slightly
3. Stayed the same
4. Decreased slightly
5. Decreased Significantly Fluctuates (sometimes increases / sometimes decreases)

CYCHANGE5

Other changes: please state.....

CYCHANGEREASON

What do you think is the reason for the change in your period:

Please select all that apply.

1. Hormone Replacement Therapy (HRT)
2. Hormonal Contraceptive
3. Other contraceptive
4. Peri-Menopause/Menopause
5. Pregnancy
6. Breast Feeding
7. Weight change
8. Change in diet
9. Change in exercise
10. Change in lifestyle
11. Illness

12. COVID-19
13. I don't know
14. None of these reasons
15. Other: Please state...

SECTION 5: SLEEP

SLEEP INTRO

The following question refers to your overall sleep quality for the **majority** of nights in the **past 7 days only**.

Please think about the quality of your sleep **overall**, such as how many hours of sleep you got, how easily you fell asleep, how often you woke up during the night (except to go to the bathroom), how often you woke up earlier than you had to in the morning, and how refreshing your sleep was.

SLEEP13

During the past 7 days, how would you rate your sleep quality overall?

Please indicate on the scale. 0 means the worst quality of sleep you can imagine and 10 means the best quality of sleep you can imagine

0. Worst quality

10. Best quality

SECTION 6 MENTAL HEALTH

Understanding how people feel about their lives is important to us. The next questions ask about aspects of your life. There are no right or wrong answers.

If you feel uncomfortable about answering a question, you do not have to answer that question. All the information we collect will be kept private and confidential. The information gathered during this research will be used for research purposes only. Nobody will be able to identify you in any published results.Over the last two weeks, that is since <DAY/MONTH>, how often have you been bothered by any of the following problems?

ASK ALL

MHEALTH1

Little interest or pleasure in doing things?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don’t know
6. Prefer not to say

MHEALTH2

Feeling down, depressed, or hopeless?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH3

Trouble falling or staying asleep, or sleeping too much?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH4

Feeling tired or having little energy?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH5

Poor appetite or overeating?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH6

Feeling bad about yourself - or that you are a failure or have let yourself or your family down?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day

5. Don't know
6. Prefer not to say

MHEALTH7

Trouble concentrating on things, such as reading the newspaper or watching television?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH8

Moving or speaking so slowly that other people could have noticed?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH9

Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

MHEALTH10

Thoughts that you would be better off dead, or of hurting yourself in some way?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

If you have been affected by any of the mental health issues raised in this survey, the following NHS webpage may be able to provide help and advice: https://www.nhs.uk/mental-health/

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

PROB1

Feeling nervous, anxious or on edge?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

PROB2

Not being able to stop or control worrying?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

PROB3

Worrying too much about different things?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

PROB4

Trouble relaxing?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

PROB5

Being so restless that it is hard to sit still?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day

5. Don't know
6. Prefer not to say

PROB6

Becoming easily annoyed or irritable?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

PROB7

Feeling afraid as if something awful might happen?

1. Not at all
2. Some days
3. More than half the days
4. Nearly every day
5. Don't know
6. Prefer not to say

SECTION 7: EMPLOYMENT, ALCOHOL AND SMOKING

The next questions ask about aspects of your life. There are no right or wrong answers. All the information we collect will be kept private and confidential. The information gathered during this research will be used for research purposes only. Nobody will be able to identify you in any published results.

EMPLOYMENT

ASK ALL

EMPL

At present are you…?

Please select your current job. If more than one applies, please choose the one you do for

the most hours.

1. Employee in full time-job (30+hours a week)

2. Employee in part-time job (less than 30 hours a week)

3. Self-employed

4. Government supported training

5. Unemployed and available for work

6. Wholly retired from work

7. Full-time education at school, college or University

8. Looking after home / family

9. Permanently sick / disabled

10. Doing something else

11. Prefer not to say [Exclusive]

ASK ALL

LIMITK

Since March 2020, has your physical or mental health affected the kind of paid work that you can do?

1. Yes
2. No
3. Don't know
4. Not applicable

LIMITA

Since March 2020, has your physical or mental health affected the number of hours of paid work that you can do?

1. Yes
2. No
3. Don't know

ASK IF LIMITK =1 OR LIMITA =1

LIMIDATE

When did your physical or mental health start to affect the paid work that you can do?

If you are not sure, please give your best guess.

[Allow from March 2020 only]

MONTH/YEAR

ALCOHOL

ASK ALL
DRINK2

Do you currently drink alcohol?

1. 1 Yes
2. 2 No
3. 3 Prefer not to say

ASK IF DRINK2=2
AlwaysTT2

Did you ever drink alcohol?

1 Yes

2 No

3 Prefer not to say

ASK IF AlwaysTT2 =1
DRINKSTOP

When did you stop drinking alcohol?

If you can't remember exactly, please enter your best guess.

[Do not allow date before participants age]

MONTH/YEAR

1. Can't remember
2. Prefer not to say

ASK IF DRINK2=1
DrinkOft2

How often do you have a drink containing alcohol?

1. Monthly or less

2. Two to four times a month

3. Two or three times a week

4. Four or five times a week

5. Daily or almost daily

IF DRINK2 =1

DRINKUNITS

How many units did you consume in the last 7 days Please enter 0 if you did not have an alcoholic drink in the last 7 days:

…units

See the guide below:

ABV is a measure of the amount of pure alcohol as a percentage of the total volume of liquid in a drink.

Type of drink	Number of alcohol units
Single small shot of spirits* (25ml, ABV 40%) *For example, Gin, rum, vodka, whisky, tequila and sambuca	1 unit
Large single shot of spirits* (35ml, ABV 40%) *For example, Gin, rum, vodka, whisky, tequila and sambuca	1.4 units
Alcopop (275ml, ABV 5.5%)	1.5 units
Small glass of red/white/rosé wine (125ml, ABV 12%)	1.5 units
Bottle of lager/beer/cider (330ml, ABV 5%)	1.7 units
Can of lager/beer/cider (440ml, ABV 5.5%)	2.4 units
Pint of lower-strength lager/beer/cider (ABV 3.6%)	2 units
Standard glass of red/white/rosé wine (175ml, ABV 12%)	2.1 units
Pint of higher-strength lager/beer/cider (ABV 5.2%)	3 units
Large glass of red/white/rosé wine (250ml, ABV 12%)	3 units
A 750ml bottle of red, white or rosé wine (ABV 13.5%)	10 units

SMOKING

SMOKENOW

Do you smoke cigarettes at all nowadays?

1. Yes
2. No
3. Prefer not to say

IF SMOKENOW = 2 or 3

SMOKECIG

Have you ever smoked cigarettes?

1. Yes
2. No
3. Prefer not to say

IF SMOKECIG= 1 AND SMOKENOW=2

SMOKECIGDATE

When did you stop smoking cigarettes (as best you can remember)?

[Do not allow date before participants age]

MONTH/YEAR

1. Prefer not to say

IF SMOKENOW =1
SMOKEFIVEYEAR

How long have you been a smoker for?

1. Less than 1 year
2. 1 year but less than 2 years
3. 2 years but less than 3 years
4. 3 years but less than 4 years
5. 4 years but less than 5 years
6. 5 years or more
7. Prefer not to say

SMOKENOW=1 OR [IF SMOKECIG= 1 AND SMOKENOW=2]
SMOKENUM

About how many cigarettes [IF SMOKENOW =1 do you smoke] [IF SMOKECIG= 1 AND SMOKENOW=2 did you smoke] each day? If you are not sure please give your best guess.

1. Less than 1
2. From 1 to 5
3. From 6 to 10
4. From 11 to 20
5. 21 or more
6. Don't know
7. Prefer not to say

VAPNOW

Do you vape/use e-cigarettes at all nowadays?

1. Yes
2. No
3. Prefer not to say

IF VAPNOW = 2 or 3
SMOKEVAP

Have you ever vaped/used e-cigarettes?

1. Yes
2. No
3. Prefer not to say

IF SMOKEVAP= 1
SMOKEVAPDATE

[Do not allow date before participants age]

When did you last vape/use e-cigarettes (as best you can remember)?

MONTH/YEAR

IF VAPNOW =1
VAPFIVEYEAR

How long have you been vaping / using e-cigarettes for?

1. Less than 1 year
2. 1 year but less than 2 years
3. 2 years but less than 3 years
4. 3 years but less than 4 years
5. 4 years but less than 5 years
6. 5 years but less than 20 years
7. 20 years or more
8. Prefer not to say

VAPNOW=1 OR [IF SMOKEVAP= 1 AND VAPNOW=2]

VAPNUM

About how many times each day [IF VAPNOW=1 do you vape / use e-cigarettes] [IF SMOKEVAP= 1 AND VAPNOW=21 did you vape / use e-cigarettes] each day? If you are not sure please give your best guess.

1. Less than 1
2. From 1 to 5
3. From 6 to 10
4. From 11 to 20
5. 21 or more
6. Don’t know
7. Prefer not to say

SECTION 8: DEMOGRAPHICS

Now we need to ask some questions about you. These questions will help us check we have reached a representative section of society and help us identify inequalities. The information you provide is kept anonymous and will not be used to identify any individual.

Disability

DISAB1

Do you consider yourself to have a disability?

1. Yes
2. No
3. Prefer not to say

ASK IF DISAB1 =1

DISAB2

[MULTICODE]

Does this disability or illness affect you in any of the following areas?

Please select all that apply.

1. Long term pain
2. Chronic health condition
3. Mobility
4. Dexterity
5. Mental health
6. Visual
7. Breathing
8. Memory
9. Hearing
10. Learning
11. Speech
12. Behavioural
13. Energy levels
14. Cognitive function
15. Other (please write in)
16. None of these [EXCLUSIVE – FIXED CODE]
17. Prefer not to say [EXCLUSIVE – FIXED CODE]

ORIENTATION

What is your sexual orientation?

1. Straight / Heterosexual
2. Homosexual / Gay / Lesbian
3. Bisexual
4. Asexual
5. Pansexual
6. Other, (please write in)[free text]

7. Prefer Not to Answer

PHONENUMB

The final questions are about contact details and further research.

We would like to collect your mobile phone number, to update our records, and if necessary contact you about this study.

What is your mobile phone number?

Mobile phone number

[number]

Please re-enter your mobile phone number

[number]

1. I have already provided a mobile phone number in the REACT study which you can use to contact me
2. I do not have a mobile number
3. Prefer not to say

POSTCODE

What is your postcode? INFO BUTTON: why are you asking for my postcode? We will use your postcode to find out the level of outdoor air pollution in your area.

Postcode: XXXX-XXXX

1. Prefer not to say

SECTION 10: RECONTACT QUESTION

ASK ALL

RECONTACT2

Imperial College London may wish to carry out some interviews to better understand the experiences, support and treatment of people with persistent symptoms of COVID-19.

You do not have to say now whether you would actually take part in the interview, just

whether you would be happy to be contacted about it.

Please select one answer

1. Yes

2. No

ASK ALL

COGNITIVECONTACT

Thank you for taking part in this important survey about the impact of the COVID-19 pandemic on the health and wellbeing of the population.

Research has suggested that long COVID can be linked to cognitive problems such as brain fog. The next stage of this study involves some brief tests to help us see whether long COVID is linked to issues with cognition and memory.

You do not need to have had COVID-19 or experienced symptoms or ill-health related to COVID-19 to take these tests. Participation from a range of people who have had and have not had COVID-19 is extremely important to understand what impact COVID-19 has had on the public.

The tests are online and will take about 15 minutes to complete.

On completing the tests, you will have the option of seeing a summary report of your scores relative to all other people who have done them.

Will you take part in the cognitive tests?

1. Yes – I will take part in the cognitive tests
2. No – I will not take part in the cognitive tests

Submit button appears here.

End Screen

[IF COGNITIVECONTACT =1]

Please click here to complete the cognitive tests reactlcsg3.e.cognitron.co.uk and enter your 8 digit access code XXXXXXXX. If you have difficulty accessing the site, please contact support@cognitron.co.uk.

You can complete this assessment at a later stage, and we may contact you to remind you to take part.

[IF COGNITIVE CONTACT = 2]

Thank you very much for taking part in this important study about the impact of the COVID-19 pandemic on the health and well-being of the population. The study will help us further our understanding of the health and wellbeing experiences of the public over the course of the COVID-pandemic.

The results of the study will be available on the Imperial College London dedicated REACT webpage in due course: https://www.imperial.ac.uk/medicine/research-and-impact/groups/react-study/real-time-assessment-of-community-transmission-findings/.

To find out more about the REACT research programme and the latest results please visit https://www.imperial.ac.uk/medicine/research-and-impact/groups/react-study/.

You can exit the questionnaire by closing your internet browser.