REACT LCR – Registration Questionnaire

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Landing Page

Registration

You have been invited to join this study because:

- You tested positive or have reported that you have tested positive for COVID-19 as part of the REACT study. This may have been for virus, antigen or antibody detected through a swab, saliva, finger prick or blood test.
- You previously attended an assessment centre and provided a sample as part of the REACT-LC or REACT-GE studies.

If you wish to enter this study please click the Start Registration button below and answer the questionnaire.

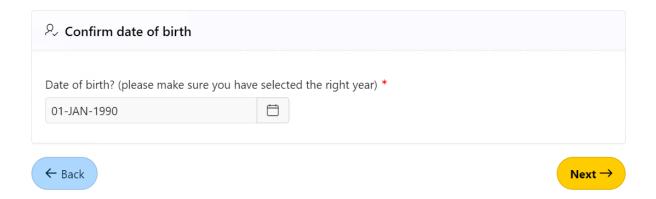
Start Registration ightarrow

Confirm date of birth

DOB CONFIRMED

Date of birth? (please make sure you have selected the right year)

- Mandatory
- Date Picker (validates against participant's date of birth)
- Updates field to 'Y' where confirmed and allows participant to carry on to next page.



Since your last visit with us SUSPECTED POSITIVE SFV

Do you suspect you have had COVID-19 since your first visit to our assessment clinic?

Mandatory

- Type: Radio Group
 - o Yes
 - o No

WHEN SUSPECTED POSITIVE SFV

Enter date when you suspected you had COVID-19 since your first visit

- Mandatory if SUSPECTED_POSITIVE_SFV = 1 (Yes)
- Type: Date Picker
 - o Minimum static: 01-JAN-2021
 - Maximum static: +0d
 - o Must be before today's date

POSITIVE SFV

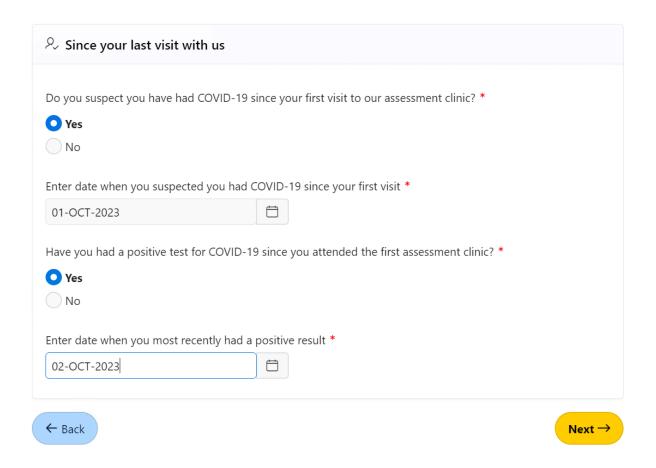
Have you had a positive test for COVID-19 since you attended the first assessment clinic?

- Mandatory
- Type: Radio Group
 - Yes
 - o No

WHEN POSITIVE SFV

Enter date when you most recently had a positive result

- Mandatory if POSITIVE_SFV = 1 (Yes)
- Type: Date Picker
 - o Minimum static: 01-JAN-2021
 - o Maximum static: +0d
 - o Must be before today's date



Your contact information

CONTACT MOBILE CONFIRM YN

Is this your current mobile phone number?

(shows the last 4 digits of their mobile number)

- Mandatory
- Type: Radio Group
 - o Yes
 - o No

CONTACT MOBILE NEW

Please enter your current mobile phone number:

- Mandatory if CONTACT_MOBILE_CONFIRM_YN = 2 (No)
- Type: Number Field
 - o Maximum length: 11 digits

CONTACT EMAIL CONFIRM YN

Is this your current email address?

(shows part of the email masked with the full email domain)

- Mandatory
- Type: Radio Group
 - o Yes
 - o No

CONTACT EMAIL NEW

Please enter your current email address:

- Mandatory if CONTACT_EMAIL_CONFIRM_YN = 2 (No)
- Type: Text Field: text
 - Matches regular expression: ^(([-a-zA-Z0-9_\+\.]+)@((\[[0-9]{1,3}\.[0-9]{1,3}\.](-9]{1,3}\.)|(([a-zA-Z0-9\-]+\.)+))([a-zA-Z]{2,4}|[0-9]{1,3})(\]?)(\s*[,|;]\s*\$))*\$

CONTACT_POSTCODE_CONFIRM_YN

Is this your current postcode?

(shows the in-code of the postcode)

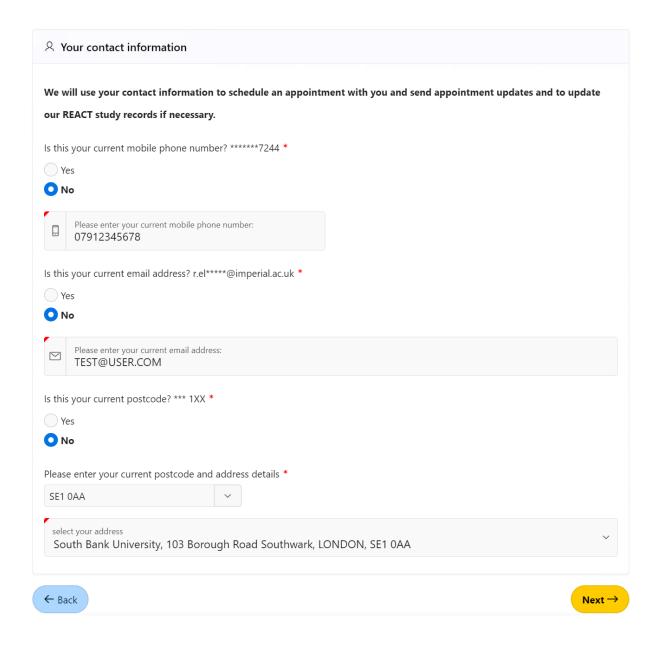
- Mandatory
- Type: Radio Group
 - o Yes
 - o No

CONTACT_ADDRESS_ID_NEW

Please enter your current postcode and address details

(user is shown drop-down Popup LOV of all UK postcodes, search as you type – selecting their correct postcode will show a list of addresses select list)

- Mandatory if CONTACT_POSTCODE_CONFIRM_YN = 2 (No)
- Type: Select List



Your symptoms

SYMPTOMS YN

Have you experienced any symptoms since your last visit

- Mandatory
- Type: Radio Group
 - o Yes
 - o No

SYMPTOMS EXPERIENCED

Which of the following symptoms have you experienced? (tick all that apply)

- Mandatory if SYMPTOMS_YN = 1 (Yes)
- Type: Checkbox Group
 - Fever COVIDSYM_01
 - Loss of sense of smell COVIDSYM 02
 - o Sore throat COVIDSYM 03
 - Runny nose COVIDSYM_04
 - Sneezing COVIDSYM_05
 - o Persistent cough COVIDSYM_06
 - Shortness of breath (compared with what's normal for you)
 COVIDSYM 07
 - Chest pain/tightness COVIDSYM 08
 - Loss of appetite COVIDSYM_09
 - o Diarrhoea COVIDSYM 10
 - Vomiting COVIDSYM 11
 - Itchy eyes COVIDSYM_12
 - Headache COVIDSYM_13
 - o Fatigue COVIDSYM_14
 - Joint pain/aches COVIDSYM_15
 - Muscle pain/aches COVIDSYM 16
 - Loss or change to sense of taste COVIDSYM 17
 - Nausea COVIDSYM 18
 - Confusion/brain fog/forgetfulness
 COVIDSYM_19
 - Dizziness/vertigo COVIDSYM_20
 - Fast or irregular heartbeat COVIDSYM_21
 - Numbness or tingling somewhere in the body COVIDSYM_22
 - Skin issues (itchy, scaly, redness, etc.)
 COVIDSYM 23
 - o Vision issues COVIDSYM_24
 - Ringing in the ears (tinnitus)
 COVIDSYM_25
 - o Hair loss COVIDSYM 26
 - Difficulty sleeping
 COVIDSYM_27
 - Sudden swelling of face or lips COVIDSYM 28
 - Red/purple sores or blisters on your feet (including toes)COVIDSYM 29
 - Leg swelling (Thrombosis)COVIDSYM_30
 - Prefer not to say
 COVIDSYM 98
 - o Other (please specify) COVIDSYM 99

SYMPTOMS_EXPERIENCED_OTHER

Please provide details of your other symptom(s).

- Mandatory if SYMPTOMS EXPERIENCED = COVIDSYM 99 (Other please specify)
- Type: Text Field: text

SYMPTOMS GT2W

Have your symptoms lasted for longer than 2 weeks?

- Mandatory if SYMPTOMS YN = 1 (Yes)
- Type: Radio Group

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- o Yes
- o No
- o Unsure as have symptoms but not yet for two weeks
- o Don't know/I can't remember

| ① Your symptoms |
|---|
| |
| We now need to ask you some further questions about your experience with COVID-19. We need to know about any symptoms you |
| had to help us understand the link between COVID-19 symptoms and our genetics. |
| Have you experienced any symptoms since your last visit * |
| O Yes |
| ○ No |
| Which of the following symptoms have you experienced? (tick all that apply) * |
| Fever |
| Loss of sense of smell |
| Loss or change to sense of taste |
| Sore throat |
| Runny nose |
| Sneezing |
| Persistent cough |
| Shortness of breath (compared with what's normal for you) |
| Chest pain/tightness |
| ✓ Headache |
| Fatigue |
| Joint pain/aches |
| Muscle pain/aches |
| Diarrhoea |
| Vomiting |
| Nausea |
| Loss of appetite |

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| Confusion/brain fog/forgetfulness |
|--|
| Dizziness/vertigo |
| Fast or irregular heartbeat |
| Leg swelling (Thrombosis) |
| Sudden swelling of face or lips |
| Red/purple sores or blisters on your feet (including toes) |
| Numbness or tingling somewhere in the body |
| Skin issues (itchy, scaly, redness, etc.) |
| Itchy eyes |
| ✓ Vision issues |
| Ringing in the ears (tinnitus) |
| Hair loss |
| ✓ Difficulty sleeping |
| Prefer not to say |
| Other (please specify) |
| Have your symptoms lasted for longer than 2 weeks? * |
| ○ Yes |
| ○ No |
| Unsure as have symptoms but not yet for two weeks |
| Don't know/I can't remember |
| |
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Symptoms Duration

SYMPTOMS DATE START NN

Symptom start date will be asked for all symptoms that have been selected in the previous section under SYMPTOMS EXPERIENCED.

{symptom name} (start date):

- Mandatory if SYMPTOMS_EXPERIENCED like '%COVIDSYM_NN%'
- Type: Date Input

Minimum date: -2y Maximum date: +0d

SYMPTOMS_CURRENTLY_EX_NN

Participants will also be asked whether they are currently experiencing for all symptoms that have been selected in the previous section under SYMPTOMS_EXPERIENCED.

Currently experiencing?

• Mandatory if SYMPTOMS_EXPERIENCED like '%COVIDSYM_NN%'

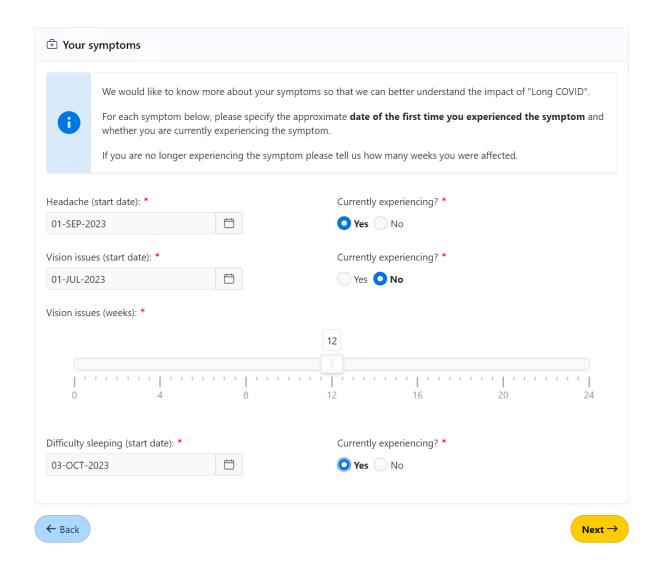
- Type: Radio Group
 - Yes
 - o No

SYMPTOMS DURATION NN

Participants will also be asked the duration in weeks of their symptoms that have been selected in the previous section under SYMPTOMS_EXPERIENCED where they have responded "No" to SYMPTOMS_CURRENTLY_EX_NN.

{symptom name} (weeks):

- Mandatory if SYMPTOMS_CURRENTLY_EX_NN = 2 (No)
- Type: Slider (weeks)
 - Minimum Value: 0Maximum Value: 24
 - Weeks selected do not exceed start date feasibility:
 to_date(:SYMPTOMS_DATE_START_NN,'dd-mon-yyyy') +
 (:SYMPTOMS_DURATION_SLIDER_SAVE_NN *7) <= sysdate+7



Your treatment

ADMITTED HOSPITAL

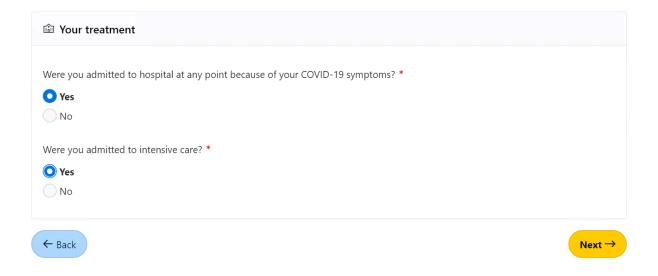
Were you admitted to hospital at any point because of your COVID-19 symptoms?

- Mandatory
- Type: Radio Group
 - o Yes
 - o No

ADMITTED ICU

Were you admitted to intensive care?

- Mandatory if ADMITTED_HOSPITAL = 1 (Yes)
- Type: Radio Group
 - o Yes
 - o No



Vaccination

VACCINATION YN

Have you ever had a COVID-19 vaccine?

- Mandatory
- Type: Radio Group
 - o Yes
 - o No

VACCINATION TYPE

Which vaccine did you receive?

- Mandatory if VACCINATION_YN = 1 (Yes)
- Type: Radio Group
 - o Pfizer/BioNTtech
 - AstraZeneca/Oxford
 - o Moderna
 - o Johnson & Johnson/Janssen
 - Don't know/I can't remember
 - Other (please specify)

VACCINATION TYPE OTHER

Please provide details of your other vaccination.

- Mandatory if VACCINATION_TYPE = 99 (Other please specify)
- Type: Text Field: Text

VACCINATION DOSES

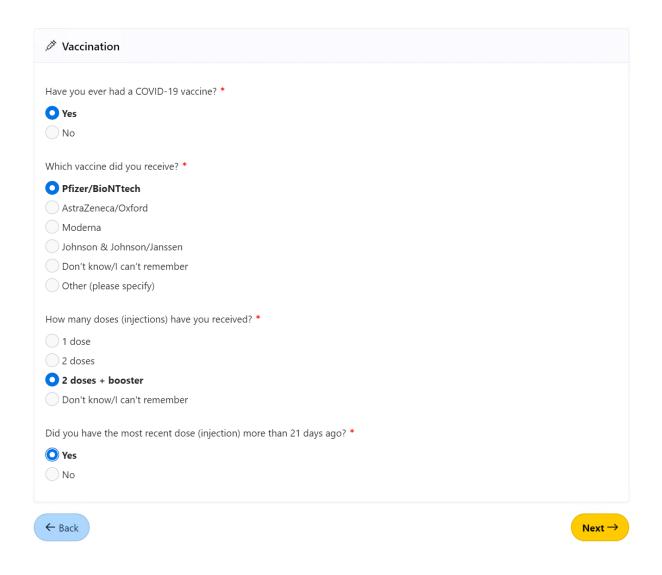
How many doses (injections) have you received?

- Mandatory if VACCINATION_YN = 1 (Yes)
- Type: Radio Group
 - o 1 dose
 - o 2 doses
 - o 2 doses + booster
 - o Don't know/I can't remember

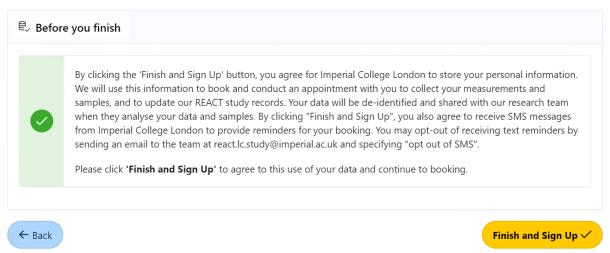
VACCINATION_DOSE_RECENT_GT21D

Did you have the most recent dose (injection) more than 21 days ago?

- Mandatory if VACCINATION_YN = 1 (Yes)
- Type: Radio Group
 - o Yes
 - \circ No



Before you finish



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$\stackrel{{\bf Q}}{\sim}$ Registration

Thank you for registering, please click on the **Bookings** link at the top of the page to view your bookings.

If you haven't already filled out the **online health and lifestyle questionnaire** please click on the link below using your unique 8 character access code (ignoring the hyphen) highlighted.

https://www.reactstudy.org/lc-followup

Questionnaire Access Code

T35T-212B