

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 →

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.

🔍 Confirm date of birth

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

01-JAN-1990



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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
 - Yes
 - 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
 - Minimum static: 01-JAN-2021
 - Maximum static: +0d
 - 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
 - No

WHEN_POSITIVE_SFV

Enter date when you most recently had a positive result


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

 Since your last visit with us

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

Yes
 No


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



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

Yes
 No

Enter date when you most recently had a positive result *



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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
 - Yes
 - No

CONTACT_MOBILE_NEW

Please enter your current mobile phone number:

- Mandatory if CONTACT_MOBILE_CONFIRM_YN = 2 (No)
- Type: Number Field
 - 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
 - Yes
 - 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}\.[0-9]{1,3}\.|\)|([a-zA-Z0-9_+\.\.])\.[a-zA-Z]{2,4}|[0-9]{1,3})(\?)\s*[;,]\s*|\s*\$)*\$

CONTACT_POSTCODE_CONFIRM_YN

Is this your current postcode?

(shows the in-code of the postcode)


- Mandatory
- Type: Radio Group
 - Yes
 - 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 contact information**

We will use your contact information to schedule an appointment with you and send appointment updates and to update our REACT study records if necessary.

Is this your current mobile phone number? *****7244 *

Yes


No

 Please enter your current mobile phone number:
07912345678

Is this your current email address? r.el*****@imperial.ac.uk *

Yes

No


 Please enter your current email address:
TEST@USER.COM



Is this your current postcode? *** 1XX *

Yes

No

Please enter your current postcode and address details *

SE1 0AA 

 select your address
South Bank University, 103 Borough Road Southwark, LONDON, SE1 0AA 

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Your symptoms

SYMPTOMS_YN

Have you experienced any symptoms since your last visit

- **Mandatory**
- **Type: Radio Group**
 - Yes
 - 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
 - Sore throat COVIDSYM_03
 - Runny nose COVIDSYM_04
 - Sneezing COVIDSYM_05
 - 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
 - Diarrhoea COVIDSYM_10
 - Vomiting COVIDSYM_11
 - Itchy eyes COVIDSYM_12
 - Headache COVIDSYM_13
 - 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
 - Vision issues COVIDSYM_24
 - Ringing in the ears (tinnitus) COVIDSYM_25
 - 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
 - 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

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

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 *

- 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

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
 - 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: 0
 - Maximum 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 symptoms

We would like to know more about your symptoms so that we can better understand the impact of "Long COVID".

For each symptom below, please specify the approximate **date of the first time you experienced the symptom** and whether you are currently experiencing the symptom.

If you are no longer experiencing the symptom please tell us how many weeks you were affected.

Headache (start date): *

Currently experiencing? * Yes No

Vision issues (start date): *

Currently experiencing? * Yes No

Vision issues (weeks): *

Difficulty sleeping (start date): *

Currently experiencing? * Yes No

Your treatment

ADMITTED_HOSPITAL


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

- Mandatory
- Type: Radio Group
 - Yes
 - No

ADMITTED_ICU

Were you admitted to intensive care?

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

 Your treatment

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

Yes
 No

Were you admitted to intensive care? *

Yes
 No

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Vaccination

VACCINATION_YN

Have you ever had a COVID-19 vaccine?

- Mandatory
- Type: Radio Group
 - Yes
 - No

VACCINATION_TYPE

Which vaccine did you receive?

- Mandatory if VACCINATION_YN = 1 (Yes)
- Type: Radio Group
 - Pfizer/BioNTtech
 - AstraZeneca/Oxford
 - Moderna
 - 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
 - 1 dose
 - 2 doses
 - 2 doses + booster
 - 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
 - Yes
 - No

 **Vaccination**

Have you ever had a COVID-19 vaccine? *

Yes

No

Which vaccine did you receive? *

Pfizer/BioNTech

AstraZeneca/Oxford

Moderna

Johnson & Johnson/Janssen

Don't know/I can't remember

Other (please specify)

How many doses (injections) have you received? *

1 dose

2 doses

2 doses + booster

Don't know/I can't remember

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


Yes


No

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Before you finish

 **Before you finish**



By clicking the 'Finish and Sign Up' button, you agree for Imperial College London to store your personal information. We will use this information to book and conduct an appointment with you to collect your measurements and samples, and to update our REACT study records. Your data will be de-identified and shared with our research team when they analyse your data and samples. By clicking "Finish and Sign Up", you also agree to receive SMS messages from Imperial College London to provide reminders for your booking. You may opt-out of receiving text reminders by sending an email to the team at react.lc.study@imperial.ac.uk and specifying "opt out of SMS".

Please click '**Finish and Sign Up**' to agree to this use of your data and continue to booking.

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[Finish and Sign Up ✓](#)

🔗 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