

National Institute for Health and Care Excellence (NICE) Long-COVID Questionnaire

Do you still have any of the following symptoms?	Before COVID infection	4 weeks after infection	12 weeks after infection
Generalized			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			
Brain fog, memory/ concentration loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delirium (older patients)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss or change to your sense of taste/smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pins and needles/numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal			
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological/psychiatric			
Symptoms of depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms of anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal			
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia/ loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose and throat			
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatological			
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>