

Derbyshire Post Covid Syndrome Questionnaire (For patients with ongoing symptoms following Coronavirus)

This questionnaire is for people in Derbyshire that have had either a confirmed diagnosis of coronavirus disease (Covid-19) or have experienced coronavirus symptoms, such as a high temperature, persistent cough, loss of taste and smell.

This questionnaire is to find out if you are continuing to experience diagnosed coronavirus or suspected coronavirus symptoms. We will add any information you provide in your confidential clinical notes, and forward on to the Post Covid Assessment Clinic, where Clinicians from different professions will assess you and will work together to ensure you receive the most appropriate care for your symptoms. You may also be referred to other services to provide additional support and treatment for your symptoms.

The information you provide will be stored as per data protection regulations, and used for purposes of clinical assessment only (for use only by Clinicians involved in your care), and will be kept in your patient records.

If there is anything that you do not wish to complete then please feel free to skip that section.

Do you agree to share the information you provide with the Post Covid Syndrome Assessment Clinic today? Yes No

Patient name and Date of Birth: _____

Date: _____

Score	Breathing	Mobility/Activity	Energy levels	Mood
NORMAL	Back to normal <input type="checkbox"/>	Back to normal <input type="checkbox"/>	Able to manage all usual activities as normal <input type="checkbox"/>	My mood and mental ability are basically normal again <input type="checkbox"/>
MILD	Not normal but I can do everything <input type="checkbox"/>	Nearly back to normal <input type="checkbox"/>	Feeling tired but managing normal activities <input type="checkbox"/>	I am OK apart from moments of low mood, anxiety or brief thinking lapses <input type="checkbox"/>
MODERATE	Breathless on hills/stairs/walking fast <input type="checkbox"/>	Having to move more slowly, but doing everything <input type="checkbox"/>	Feeling tired, needing to rest frequently, restricting normal activities <input type="checkbox"/>	I suffer most days from low mood <u>or</u> anxiety <input type="checkbox"/>
SEVERE	Stops me doing some things <input type="checkbox"/>	Struggling with some activities <input type="checkbox"/>	Significant tiredness, occasionally unable to participate in normal activities <input type="checkbox"/>	My memory is now poor and I struggle to think <input type="checkbox"/>
	Breathless on minimal activity <input type="checkbox"/>	Barely getting around <input type="checkbox"/>	Significant tiredness, unable to participate in normal activities each day <input type="checkbox"/>	I feel suicidal <u>or</u> I feel hopelessness <u>or</u> I just cannot think or remember at all <input type="checkbox"/>
	Breathless at rest <input type="checkbox"/>	Bed bound <input type="checkbox"/>	Fatigue is debilitating and persistent dependent on others for all tasks <input type="checkbox"/>	I hear voices <u>or</u> I am losing my grip on reality <input type="checkbox"/>

Please tick the description in each column that best describes how you currently feel so that a Clinician can refer you to the appropriate services for your symptoms

What was your health like before you had Covid, some examples are below to assist you:

I did not have any restrictions on my life (please comment below)

I had some restrictions, eg mobility (please comment below)

I had existing restrictions on my life (please comment below)

Are you living with a long term health condition(s)? **Yes** **No**

If yes, please list what long term health condition(s) you have, for example, diabetes, a breathing condition, or a heart related condition. How does this affect you? Please explain below.

Were you admitted to hospital with a diagnosis of Covid, or were you admitted to hospital with Covid like symptoms?

Yes **No**

If yes, to the above, have you had any further medical problems? Please explain below.

Have you needed to go back to hospital since your discharge or needed to seek medical help/advice relating to Covid like symptoms? Please explain below.

Were you re-admitted to hospital? **Yes** **No**

Details:

Have you used any other health services since discharge from hospital for Covid like symptoms (for example, your GP?), If Yes, please explain below.

Yes No

How have you been affected by Coronavirus?

1. Breathlessness

On a scale of 0-10, with 0 being not breathless at all, and 10 being extremely breathless, how breathless are you: (Answer N/A if you do not perform this activity)

a) At rest?

Now **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Before Covid **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

b) On dressing yourself?

Now **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Before Covid **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

N/A

c) On walking up a flight of stairs?

Now **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Before Covid **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

N/A

2. Cardiac (heart related) chest pain (angina)

Do you have any chest discomfort, shortness of breath, cardiac chest pains or symptoms of angina? **Yes** **No**

If yes, is this new (following Covid) or old? **New** **Old**

If yes, how is it affecting you in activities of daily living on the scale of 0-10 below (0 being no impact, 10 being significant impact)

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

<p>3. Palpitations or feeling of your own heart flutters</p>	<p>Do you have symptoms of heart palpitations/flutterers? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, is this new (following Covid) or old (prior to Covid)? New <input type="checkbox"/> Old <input type="checkbox"/></p> <p>If yes (it is a new symptom), how is it affecting you in activities of daily living on the scale of 0-10 below (0 being no impact, 10 being significant impact)</p> <p>0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>4. Stroke</p>	<p>Have you had a stroke since having Covid like symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, has a stroke had an impact on your ability to carry out your normal daily activities?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>5. Throat/ breathing problems</p>	<p>Have you developed any changes in the sensitivity of your throat such as troublesome cough or noisy breathing? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>6. Voice</p>	<p>Have you or your family noticed any changes to your voice such as difficulty being heard, changed quality of the voice, your voice tiring by the end of the day or an inability to change the pitch of your voice? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>7. Swallowing</p>	<p>Are you having difficulties eating, drinking or swallowing such as coughing, choking or avoiding any food or drinks? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>8. Nutrition (Eating)</p>	<p>Are you or your family concerned that you have ongoing weight loss or any ongoing nutritional concerns as a result of Covid-19? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Please rank your appetite or interest in eating on a scale of 0-10 since Covid-19 (0 being same as usual/no problems, 10 being very severe problems/reduction)</p> <p>0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>

<p>9. Mobility (Movement)</p>	<p>On a 0-10 scale, how severe are any problems you have in walking about, for example, 0 means you have no problems, 10 means you are completely unable to walk about.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>10. Fatigue or Exhaustion</p>	<p>Do you become fatigued (extremely tired) more easily compared to before your illness? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, how severely does this affect your mobility (movement), personal care, activities or enjoyment of life? (0 being not affecting, 10 being very severely impacting)</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>11. Personal Care</p>	<p>On a 0-10 scale, how severe are any problems you have in personal care such as washing and dressing yourself? (0 means you have no problems, 10 means you are completely unable to do my personal care)</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>12. Continence (control of bowel or bladder)</p>	<p>Since your illness are you having any <u>new</u> problems with:</p> <ul style="list-style-type: none"> • controlling your bowel Yes <input type="checkbox"/> No <input type="checkbox"/> • controlling your bladder Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>13. Usual Activities</p>	<p>On a 0-10 scale, how severe are any problems you have in doing your usual activities, such as household chores, leisure activities, work or study? 0 means you have no problems, 10 means you are completely unable to do your usual activities.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>14. Pain/ discomfort</p>	<p>On a 0-10 scale, how severe is any pain or discomfort you have? 0 means you have no pain or discomfort, 10 means you have extremely severe pain</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>15. Cognition (the ability to think, memory, clarity of thought, how we organise ourselves, how we process things)</p>	<p>Since your illness have you had new or worsened difficulty with:</p> <ul style="list-style-type: none"> • concentrating? Yes <input type="checkbox"/> No <input type="checkbox"/> • short term memory? Yes <input type="checkbox"/> No <input type="checkbox"/>

<p>16. Cognitive-Communication (how our ability to think and organise our thoughts impacts on how we are able to communicate with others both verbally and non-verbally)</p>	<p>Have you or your family noticed any change in the way you communicate with people, such as making sense of things people say to you, putting thoughts into words, difficulty reading or having a conversation? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>17. Anxiety (feeling worried or nervous)</p>	<p>On a 0-10 scale, how severe is the anxiety you are experiencing? 0 means you are not anxious, 10 means you are extremely anxious.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>18. Depression (sadness or lack of interest)</p>	<p>On a 0-10 scale, how severe is the depression you are experiencing? 0 means you are not depressed, 10 means you have extreme depression.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>19. Post Traumatic Stress Disorder (PTSD - an anxiety disorder caused by very stressful, frightening or distressing events)</p>	<p>a) Have you had any unwanted memories of your illness or hospital admission whilst you are awake, so not including dreams? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, how much do these memories bother you? (is the distress: mild <input type="checkbox"/> / moderate <input type="checkbox"/> / severe <input type="checkbox"/> / extreme <input type="checkbox"/>)</p> <p>b) Have you had any unpleasant dreams about your illness or hospital admission? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, how much do these dreams bother you? (is the distress: mild <input type="checkbox"/> / moderate <input type="checkbox"/> / severe <input type="checkbox"/> / extreme <input type="checkbox"/>)</p> <p>c) Have you tried to avoid thoughts or feelings about your illness or hospital admission? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, how much effort do you make to avoid these thoughts or feelings? (mild <input type="checkbox"/> / moderate <input type="checkbox"/> / severe <input type="checkbox"/> / extreme <input type="checkbox"/>)</p> <p>d) Are you currently having thoughts about harming yourself in any way? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>20. Overall Health</p>	<p>How poor do you feel your overall health is? (10 means the worst health you can imagine. 0 means the best health you can imagine).</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Before Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>

Covid-19 Follow-up screening tool (for use by Clinician in Post Covid Syndrome Assessment Clinic/Multi-Disciplinary Team)

Patient Name and Date of Birth _____

Date _____

Score	Breathing	Mobility/Activity	Energy levels	Mood
NORMAL	Back to normal <input type="checkbox"/>	Back to normal <input type="checkbox"/>	Able to manage all usual activities as normal <input type="checkbox"/>	My mood and mental ability are basically normal again <input type="checkbox"/>
MILD	Not normal but I can do everything <input type="checkbox"/>	Nearly back to normal <input type="checkbox"/>	Feeling tired but managing normal activities <input type="checkbox"/>	I am OK apart from moments of low mood, anxiety or brief thinking lapses <input type="checkbox"/>
MODERATE	Breathless on hills/stairs/walking fast <input type="checkbox"/>	Having to move more slowly, but doing everything <input type="checkbox"/>	Feeling tired, needing to rest frequently, restricting normal activities <input type="checkbox"/>	I suffer most days from low mood <u>or</u> anxiety <input type="checkbox"/>
SEVERE	Stops me doing some things <input type="checkbox"/>	Struggling with some activities <input type="checkbox"/>	Significant tiredness, occasionally unable to participate in normal activities <input type="checkbox"/>	My memory is now poor and I struggle to think <input type="checkbox"/>
	Breathless on minimal activity <input type="checkbox"/>	Barely getting around <input type="checkbox"/>	Significant tiredness, unable to participate in normal activities each day <input type="checkbox"/>	I feel suicidal <u>or</u> I feel hopelessness <u>or</u> I just cannot think or remember at all <input type="checkbox"/>
	Breathless at rest <input type="checkbox"/>	Bed bound <input type="checkbox"/>	Fatigue is debilitating and persistent dependent on others for all tasks <input type="checkbox"/>	I hear voices <u>or</u> I am losing my grip on reality <input type="checkbox"/>

Please tick the description in each column that best describes how the patient currently feels following conversation with Clinician