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# Wellcome Trust LPS Questionnaire Resource

**Updated: June 2021**

**Notes**

1. To reference data collected using this resource describe with:

*Data gathered from questionnaire(s) provided by Wellcome Longitudinal Population Study Covid-19 Steering Group and Secretariat (221574/Z/20/Z)*

1. To contact the secretariat for updates, support and advice email

 **wellcomecovid-19@bristol.ac.uk**

1. If using logos, please use the Wellcome Covid-19 logo on your questionnaire for participants alongside your own institution.
2. Please tag [@covid19qs](https://twitter.com/covid19qs) on twitter and/or link to <http://www.bristol.ac.uk/alspac/researchers/wellcome-covid-19/> where appropriate.

# a. Formatting & Details

All questions that were not from ALSPAC questionnaire 1 and 2 have been given a source tag.

**Red text** indicates where the question’s original wording has been amended.

*[[Italic text in double squares bracket is note about question, not to be shown to participant.]]*

# Long COVID

## Your medical history

1. **In general, in the 3 months before the COVID-19 outbreak in March 2020, would you say your health was…**
	1. Excellent
	2. Very good
	3. Good
	4. Fair
	5. Poor
	6. Don’t know
	7. Prefer not to say
2. **Were you contacted by letter or text message to say you are at severe risk from COVID-19 due to an underlying health condition and should be shielding?**
	1. Yes
	2. No

## Your symptoms during the pandemic 2020 - 2021

1. **In this question we would like to know if you have had ANY of the following symptoms from ANY illness you have had over the last 6 months, whether or not you think they were related to COVID-19.**You will have the opportunity to let us know about other symptoms later on in the questionnaire.
If you have had any of these symptoms during the time periods shown below, please tick the box to indicate ‘Yes’. Leave the box blank if you have not had that symptom. We will interpret unticked boxes as ‘No’.

|  |  |  |  |
| --- | --- | --- | --- |
|  | November – December 2020 | January – February 2021 | March – April 2021 |
| a. Fever |  |  |  |
| b. Feeling feverish |  |  |  |
| c. Chills (feeling too cold) |  |  |  |
| d. Loss or change in sense of smell |  |  |  |
| e. Loss or change in sense of taste |  |  |  |
| f. Runny nose |  |  |  |
| g. Sore or painful throat |  |  |  |
| h. Shortness of breath or trouble breathing affecting normal activities |  |  |  |
| i. New persistent cough |  |  |  |
| j. Decrease in appetite |  |  |  |
| k. Diarrhoea |  |  |  |
| l. Unusual muscle pains or aches |  |  |  |
| m. Confusion, disorientation, or drowsiness |  |  |  |
| n. Unusual fatigue/feeling unusually tired |  |  |  |
| o. Headache |  |  |  |
| p. Chest pain |  |  |  |

1. **Has a doctor told you that you have developed a new health condition, illness or disability since March 2020? Please do not include a diagnosis of COVID-19 infection itself, which is covered later in this questionnaire.**
	1. I have not developed a new health condition since March 2020 (Skip to Q4)

I have developed…

|  |  |
| --- | --- |
| I have developed… | Has a doctor told you that this new health condition developed because of the COVID-19 infection? |
|  | **Yes** | **No** |
| a. High blood pressure or hypertension |  |  |
| b. A heart condition e.g., angina, heart attack, myocardial infarction, coronary thrombosis, congestive heart failure |  |  |
| c. Diabetes or high blood sugar |  |  |
| d. A stroke (cerebral vascular disease) |  |  |
| e. Arthritis (including osteoarthritis, or rheumatism) |  |  |
| f. Cancer or a malignant tumour (including leukaemia) |  |  |
| g. A condition affecting the mind or brain, e.g., expression, anxiety, and other conditions such as dementia |  |  |
| h. Post-viral fatigue |  |  |
| i. Post-COVID syndrome |  |  |
| j. A blood clot in the leg or lung |  |  |
| k. A condition affecting the nervous system outside the brain |  |  |
| l. A condition affecting the kidneys |  |  |
| m. Thyroid disease |  |  |
| n. Other condition (please specify) |  |  |

1. **Do you think that you have current have or have ever had COVID-19?**
	1. Yes, confirmed by a positive test
	2. Yes, based on medical advice
	3. Yes, based on strong personal suspicion
	4. Unsure
	5. No (Go to section 2.3)
	6. Prefer not to say (Go to section 2.3)
2. **When do you think you first got (or might have got) COVID-19? If you do not remember exactly, please put your best estimate.**
	1. DD/MM/YYYY
	2. Don’t know
	3. Prefer not to answer
3. **In the first 4 weeks of illness, did you look for any medical help for any symptoms you think may have been caused by COVID-19? Please select all that apply.**
	1. Yes – discussed symptoms with doctor/GP/practice nurse
	2. Yes – discussed symptoms with NHS 111 in England, Wales and Northern Ireland or NHS 24 in Scotland
	3. Yes – accessed online advice at NHS 111 in England, Wales and Northern Ireland or NHS 24 in Scotland
	4. Yes – visited pharmacist
	5. Yes – visited A&E or walk-in centre
	6. No
	7. Don’t know
	8. Prefer not to say
4. **Did you look for any medical help for any symptoms you had more than 4 weeks after your symptoms began, that you think ma yhave been caused by COVID-19? Please select all that apply.**
	1. Yes – discussed symptoms with doctor/GP/practice nurse
	2. Yes – discussed symptoms with NHS 111 in England, Wales and Northern Ireland or NHS 24 in Scotland
	3. Yes – accessed online advice at NHS 111 in England, Wales and Northern Ireland or NHS 24 in Scotland
	4. Yes – visited pharmacist
	5. Yes – visited A&E or walk-in centre
	6. No
	7. Don’t know
	8. Prefer not to say
5. **Have you ever had to stay in hospital because of COVID-19 symptoms?**
	1. Yes
	2. No
	3. Don’t know
	4. Prefer not to say
6. **Do you think you have caught COVID-19 more than once?**
	1. Yes, confirmed by a second positive test
	2. Yes, based on medical advice
	3. Yes, based on strong personal suspicion
	4. Unsure (Go to Q9)
	5. No (Go to Q9)
	6. Prefer not to say (Go to Q9)
7. **When did you catch COVID-19 the second time? If you do not remember exactly, please put your best estimate?**
	1. DD/MM/YYYY
	2. Don’t know
	3. Prefer not to say
8. **Thinking of your last, or only, episode of COVID-19, have you now recovered to normal?**
	1. Yes, I am back to normal
	2. No, I still have some or all of my symptoms
9. **How long have you had / did you have COVID-19 symptoms overall. Please include time spent with mild symptoms and the time in between symptoms if these have been coming and going.** If you have caught COVID-19 more than once, please answer about the longest episode of illness you experience**.**
	1. Less than 2 weeks
	2. 2 – 3 weeks
	3. 4 – 12 weeks
	4. More than 12 weeks
10. **For how long were you have you been able to function has normal due to COVID-19 symptoms**
	1. I was always able to function as normal (Go to Q13)
	2. 1 – 3 days
	3. 4 – 6 days
	4. 7 – 13 days
	5. 2 – 3 weeks
	6. 4 – 12 weeks
	7. 12+ weeks
11. **How many days were you or have you been so unwell that you stayed in bed or on the sofa?**
	1. None
	2. 1 – 3 days
	3. 4 – 6 days
	4. 7 – 12 days
	5. 2 – 3 weeks
	6. 4 – 12 weeks
	7. 12+ weeks
12. **Did you have any of the following problems 12 weeks (or more) after first catching COVID-19? Please only consider symptoms that are not explained by another reason. Tick all that apply.**
	1. I was back to my usual self (Go to section 2.3)
	2. Breathing problems, e.g. breathlessness, pain on breathing, cough
	3. Altered sense of taste or smell
	4. Problems thinking and communicating e.g., brain-fog, memory problems, difficulty concentrating, decreased alertness, confusion, difficulty speaking
	5. Heart problems, e.g. chest pain, palpitation
	6. Light-headedness / dizziness on standing
	7. Abdominal problems, e.g. tummy pain, diarrhoea, appetite loss
	8. Muscle problems, e.g. muscle aches, weakness, severe fatigue
	9. Altered feelings in your body, e.g. unusual tingling, pain
	10. Problems relating to mood, e.g. anxiety, feeling ‘down’, or irritable
	11. Problems sleeping, e.g. poor sleep or excessive sleep
	12. Skin rashes
	13. Bone / joint pain
	14. Headaches
13. **How much difficulty did you have with the following activities 12 weeks (3 months) after your COVID-19 illness began?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **No difficulty** | **Mild** | **Moderate** | **Severe** | **Extreme/Unable to do** | **Compared to before COVID-19, are you** |
| **Better**  | **Worse** | **Same** |
| Standing for long periods, such as 30 minutes? |  |  |  |  |  |  |  |  |
| Taking care of your household responsibilities? |  |  |  |  |  |  |  |  |
| Learning a new task, e.g. learning how to get to a new place? |  |  |  |  |  |  |  |  |
| Joining in community activities (e.g. festivities, religious, other)? |  |  |  |  |  |  |  |  |
| Being emotionally affected by your health problems? |  |  |  |  |  |  |  |  |
| Concentrating on doing something for ten minutes? |  |  |  |  |  |  |  |  |
| Walking a long distance such as 1 kilometre or half a mile? |  |  |  |  |  |  |  |  |
| Washing your whole body? |  |  |  |  |  |  |  |  |
| Getting dressed? |  |  |  |  |  |  |  |  |
| Dealing with people you do not know? |  |  |  |  |  |  |  |  |
| Maintaining a friendship? |  |  |  |  |  |  |  |  |
| Your day-to-day work\* / school? |  |  |  |  |  |  |  |  |

\* Includes paid and unpaid work

1. **Thinking of how you felt 12 weeks after your COVID-19 illness began, what did you need help with because of COVID-19? Please select all that apply**
	1. Getting essential shopping, e.g. food or medication
	2. Preparing food and/or drink
	3. Washing and dressing
	4. Housework, e.g. laundry, cleaning, or hoovering
	5. Managing household responsibilities, e.g. finances or paying bills
	6. Day-to-day work / study
	7. Childcare or other caring responsibilities
	8. Letting other people know about my illness (e.g. employer, university, family)
	9. Getting about (travel), e.g. driving
	10. I have not needed any additional support
2. **What help or support have you found helpful, 12 weeks after your COVID-19 illness began?** Please select all that apply.
	1. Self-organised group or network of people with the same condition, e.g. on social media
	2. Local volunteer network
	3. Support from people you live with
	4. Support from neighbours
	5. Support from a religious group
	6. Support from a charity
	7. Support from family
	8. Support from friends
	9. Support from your local council
	10. Support from your GP or the NHS
	11. I’m not sure what was most helpful
3. **What help do you think would be most useful for people who continue to have symptoms 12 weeks after their COVID-19 illness began?** Please select the top three most useful.
	1. Network of people with the same condition
	2. Reliable, easily accessible information in one place
	3. Access to financial support
	4. Access to supermarket / food deliveries
	5. Access to therapy – e.g. occupational or physical therapy
	6. Access to psychological support
	7. Access to a doctor and if necessary, specialist care
	8. I’m not sure what would be most useful

## Testing for Coronavirus

1. **Have you ever had a swab test to see if you have COVID-19 (of your nose and/or throat, or saliva)?** Please select all that apply
	1. Yes, because of my job / studying (e.g. routine swab tests) \* (Go to Q3)
	2. Yes, because I had symptoms
	3. Yes, because I had been in contact with someone who had COVID-19
	4. Yes, because I have taken part in a research study
	5. Yes, because of travel
	6. Yes, because I needed a medical procedure (not related to COVID-19)
	7. Yes, because my local areas was involved in routine swabbing
	8. Yes, other
	9. No (go to Q5)
		* + 1. \* If you have selected this answer, please go straight to Question C3 and DO NOT answer C2 (even if you additionally select other answers that direct you to C2).
2. **Can you provide the dates of your swab / saliva test and results? If you can’t remember exactly, please give your best estimate.** If you have had routine swab tests because of your work or study, please skip to Q3.

|  |  |
| --- | --- |
|  | Test results |
| **Date of test (DD/MM/YYYY)** | **Positive** | **Negative** | **Unknown** | **Prefer not to say** |
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| \_ \_ / \_ \_ / \_ \_ \_ \_ |  |  |  |  |

1. **Can you provide the dates of your tests and results where they were positive (if any)? Please include all positive test results you have received, whether due to routine testing or for any other reason. Do not include negative or inconclusive results. If you can’t remember exactly, please give your best estimate.**
	1. (DD / MM / YYYY) \_ \_ / \_ \_ / \_ \_ \_ \_
		* + 1. **Please go to Q5**
2. **When did you start routine testing for your work / study?** If you can’t remember exactly, please give your best estimate.
	1. (DD / MM / YYYY) \_ \_ / \_ \_ / \_ \_ \_ \_
	2. Don’t know
3. **Have you ever had a blood or finger-prick test to see if you had past infection with COVID-19 sometimes called antibody or serology tests)?** Please select all that apply
	1. Yes, because I previously had symptoms
	2. Yes, because I took part in a research study
	3. Yes, because of my job / studying (e.g. routine antibody tests)
	4. Yes, other
	5. No (Go to section 2.4)
	6. Don’t know (Go to section 2.4)
4. **Can you provide the dates of your bloody or finger-prick tests and results?** If you can’t remember exactly, please give your best estimate.

|  |  |
| --- | --- |
|  | Test results |
| **Date of test (DD/MM/YYYY)** | **Positive** | **Negative** | **Unknown** | **Prefer not to say** |
| \_ \_ / \_ \_ / \_ \_ \_ \_  |  |  |  |  |
| \_ \_ / \_ \_ / \_ \_ \_ \_ |  |  |  |  |
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## Vaccination

1. **Have you been invited to have a COVID-19 vaccine?**
	1. Yes
	2. No (Go to Section 3)
	3. Don’t know (Go to Section 3)
	4. Prefer not to say (Go to Section 3)
2. **Have you had at least one COVID-19 vaccine injection?**
	1. Yes
	2. No – but I intend to (Go to Section 3)
	3. No – and I do not intend to (Go to Section 3)
	4. Don’t know (Go to Section 3)
	5. Prefer not to say (Go to Section 3)

If you have your vaccine card, please use that to help answer the following questions.

1. **What is the name of the vaccine you received?**
	1. Oxford AstraZeneca
	2. Pfizer BioNTech
	3. Moderna
	4. Janssen / Johson & Johnson
	5. Valneva
	6. Novavax
	7. Other – please specify:
	8. Don’t know
2. **When was your first COVID-19 vaccine injection?** If you can’t remember exactly, please put your best estimate.
	1. (DD / MM / YYYY) \_ \_ / \_ \_ / \_ \_ \_ \_
	2. Don’t know
3. **Have you had your second COVID-19 vaccine injection yet?**
	1. No (Go to Q8)
	2. Yes
4. **What is the name of the second dose vaccine you received?**
	1. Oxford AstraZeneca
	2. Pfizer BioNTech
	3. Moderna
	4. Janssen / Johnson & Johnson
	5. Valneva
	6. Novavax
	7. Other – please specify:
	8. Don’t know
5. **When was your second COVID-19 vaccine injection?** If you can’t remember exactly, please put your best estimate.
	1. (DD / MM / YYYY) \_ \_ / \_ \_ / \_ \_ \_ \_
	2. Don’t know
6. **Did you have ongoing symptoms from COVID-19 in the week before you were given your first COVID-19 vaccine injection?**
	1. Yes
	2. No (Go to Section 3)
	3. Don’t know (Go to Section 3)
7. **Please tell us whether your symptoms from your COVID-19 illness changed 2 week s or later after having your first COVID-19 vaccine injection.**
	1. Yes – They all got better
	2. Yes – Some of them got better
	3. No change
	4. Yes – Some of them got worse
	5. Yes – they all got worse
	6. Some improved and others got worse
	7. It has not yet been 2 weeks since my first COVID-19 vaccine injection