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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.]]*

# Physical Health

## Pre-existing health conditions

**This section is asking about your current health and whether you have experienced any COVID-19, or other symptoms, so far.**

1. **Are you or do you currently have any of the following:**
	1. **If yes, please tell us exactly what you have:**
		1. Organ transplant recipient
		2. Diabetes (Type I or II)
		3. Heart disease or heart problems
		4. Hypertension (high blood pressure)
		5. Overweight
		6. A recent stroke
		7. Kidney disease
		8. Liver disease
		9. Anaemia
		10. Asthma
		11. Other lung condition such as COPD, bronchitis or emphysema
		12. Cancer
		13. Condition affecting the brain and nerves (e.g. Dementia, Parkinson’s, Multiple Sclerosis)
		14. A weakened immune system/reduced ability to deal with infections (as a result of a disease or treatment)
		15. Depression
		16. Anxiety
		17. Psychiatric disorder
	2. **If yes, to a, b, c, k, l, m, q**
2. **Please tell us the type**
	1. [Free text]
	2. **If yes to n**
3. **Please tell us why your immune system is weakened**

[Free text]

1. **For each of the following questions please consider your *usual* situation and respond Yes or No**
	* 1. In general, do you have health problems that require you to limit your activities?
		2. Do you need someone to help you on a regular basis?
		3. In general, do you have any health problems that require you to stay at home?
		4. If you need help, can you count on someone close to you?
		5. Do you regularly use a stick, walker or wheelchair to move about?
			+ 1. Yes
				2. No
2. **Have you been 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
3. **Do you currently take any regular medication?**
	1. Yes
	2. No
4. **Do you usually bring up phlegm/sputum/mucus from the lungs, or do you usually feel like you have mucus in your lungs that is difficult to bring up, when you don’t have a cold?**

*[Source: UK BioBank]*

* 1. Yes, always
	2. Yes, Sometimes
	3. No
	4. Unsure

## COVID symptoms

1. **We are interested in whether you have experienced any symptoms listed below since** [the beginning of the pandemic/the first lockdown/the second lockdown], **which began on** [March 2020/ 23rd March 2020/5th January 2021].

**Please complete the table for *any* of the symptoms you have had and when you had them, if you can remember.** Please complete for any symptoms that were experienced irrespective of whether or not you saw a doctor and irrespective of whether or not you were told you had flu, or Covid-19 (corona virus) or any other diagnosis. Please give your best estimate or leave blank if you can’t remember.

*[[Months to be edited according to time-frame used]]*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Not Had  | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 |
| Decrease in appetite |  |  |  |  |  |  |
| Nausea and/or vomiting |  |  |  |  |  |  |
| Diarrhoea  |  |  |  |  |  |  |
| Abdominal pain/tummy ache |  |  |  |  |  |  |
| Runny nose |  |  |  |  |  |  |
| Sneezing |  |  |  |  |  |  |
| Blocked nose |  |  |  |  |  |  |
| Sore eyes |  |  |  |  |  |  |
| Loss of sense of smell or taste |  |  |  |  |  |  |
| Sore throat |  |  |  |  |  |  |
| Hoarse voice |  |  |  |  |  |  |
| Headache (if more often or worse than usual) |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |
| NEW Persistent cough |  |  |  |  |  |  |
| Tightness in the chest |  |  |  |  |  |  |
| Chest pain |  |  |  |  |  |  |
| Shortness of breath (affecting normal activities) |  |  |  |  |  |  |
| Fever (feeling too hot) |  |  |  |  |  |  |
| Chills (feeling too cold) |  |  |  |  |  |  |
| Difficulty sleeping |  |  |  |  |  |  |
| Felt more tired than normal |  |  |  |  |  |  |
| Severe fatigue (e.g. inability to get out of bed) |  |  |  |  |  |  |
| Numbness or tingling somewhere in the body |  |  |  |  |  |  |
| Feeling of heaviness in arms or legs |  |  |  |  |  |  |
| Achy muscles |  |  |  |  |  |  |
| Raised, red, itchy areas on the skin |  |  |  |  |  |  |
| Sudden swelling of the face or lips |  |  |  |  |  |  |
| Red/purple sores or blisters on your feet (including toes) |  |  |  |  |  |  |

1. **If you have had any of the symptoms above in the last week:**

When did the first one start?

1 2 3 4 5 6 7 days ago

Can’t remember

When did the lastone finish?

1 2 3 4 5 6 7 days ago

Can’t remember

I still have it/them

1. **In the last week have you had your temperature taken**?

Yes

No

1. **[If yes to 3] Who took your temperature?**

A doctor/nurse or other health professional

I did

It was taken by someone else

1. **[If yes to 3] If you can remember, what was the highest temperature reading?**

[Free text] °C

1. **Have you been in close contact with anyone with COVID-19 in the last two weeks?**

Yes, I was in contact with a confirmed/tested COVID-19 case

Yes, I was in contact with a suspected COVID-19 case

No, not to my knowledge

## Treatment for COVID

This section is for participants who have had COVID-19.

1. **Did you seek or receive treatment for your COVID-19 symptoms?**

No (Skip to next section)

Yes

1. **Please tell us what medical attention you received for your COVID-19 symptoms (please tick all that apply)**

I contacted NHS 111, by phone or online

I visited a pharmacist

I consulted GP/practice nurse over the phone or online

I consulted GP/practice nurse face to face

1. **Did you go to Accident and Emergency (A&E) for your COVID-19 symptoms?**

No (Skip to next section)

Yes

1. **Were you admitted to a hospital bed?**

No (Skip to next section)

Yes

1. **How many nights did you stay in hospital? (please provide a rough estimate if you can’t remember the exact number)**

\_ \_\_ nights

1. **Did you receive any breathing support during your hospital stay? (please tick all that apply)**

No

Yes, I received oxygen (through an oxygen mask, no pressure applied)]

Yes, I received non-invasive ventilation (through a special oxygen mask which pushes oxygen into your lungs, also called CPAP)

Yes, I received invasive ventilation (via a tube inserted in the throat. People are usually asleep for this procedure)

## Vaccination Intentions

1. **Which of the following best describes your thoughts about being vaccinated against coronavirus (COVID-19), once a vaccine becomes available to you? [Choose one response] \***
	1. I’ve not yet thought about getting vaccinated against COVID-19 (Go to next section)
	2. I’m not yet sure about getting vaccinated against COVID-19 (Go to next section)
	3. I’ve decided I don’t want to get vaccinated against COVID-19 (Go to Q2)
	4. I’ve decided I do want to get vaccinated against COVID-19 (Go to Q3)
2. **What is the main reason for your response? (tick all that apply)**
	1. I have had a test positive COVID-19 infection and believe I am immune
	2. I have had symptoms but not been test, however, believe I have had COVID-19 and am now immune
	3. I do not believe a vaccine will be safe
	4. I do not believe COVID-19 is that dangerous
	5. Other … [Free text]
3. **What is the main reason for your response? (tick all that apply)**
	1. I believe everyone should have the vaccine when one comes out in order to stop the infection
	2. I believe the vaccine will be safe and effective
	3. Other, please describe

## COVID Testing

1. **Have you ever had a test to see if you have or have had COVID-19? Tick all that apply:**
	1. No (Go to Q9)
	2. Yes, because I had symptoms
	3. Yes, because I have been in contact with someone who had COVID-19
	4. Yes, because of my job
	5. Yes, for another reason, please describe … [Free text]
2. **What kind of test have you had (tick all that apply)?**
	1. A swab test (swab taken from the your throat or nose or saliva) which tests for *active* infection, including PCR tests.
	2. An antibody test (this usually involves a drop of blood taken from your finger) which tests for *past* infection, including tests with a lateral flow device.
	3. Other, Please describe
	4. Don’t know
	5. **Set up branching such that participant completes q3 & 4 if yes to swab test, q5 & 6 if yes to antibody test, q5 & 6 if yes to other. Otherwise go to question 12**
3. **Have you had a positive result from a swab test?**
	1. No (Go to Q5)
	2. Yes
	3. Don’t know
4. **When was the sample taken for the test that came back positive? (give the latest date if you have had more than one)**
	1. DD/MM/YY
5. **Have you had a positive result from an antibody test?**
	1. No     (Go to Q7)
	2. Yes
	3. Don’t know
6. **When was the sample taken for the test that came back positive? (give the latest date if you have had more than one)**
	1. DD/MM/YY
7. **Have you had a positive result from the other test?**
	1. No     (Go to Q9)
	2. Yes
	3. Don’t know
8. **When was the sample taken for the test that came back positive? (give the latest date if you have had more than one)**
	1. DD/MM/YY
9. **Do you think that you currently have or have had COVID-19?**
	1. Yes, confirmed by a positive test
	2. Yes, suspected by a doctor but not tested
	3. Yes, my own suspicions
	4. No (Go to Q11)
10. **If yes, when were you told/when did you think you first had COVID-19?**
	* + - 1. DD/MM/YYYY
11. **Do you know anyone who has died from COVID-19? (tick all that apply)**
	1. Yes, family member(s)
	2. Yes, friend(s)
	3. Yes, someone else
	4. No
	5. Prefer not to say
12. **Were you hospitalized for treatment of your COVID-19 disease?**
	1. Yes
	2. No
	3. Don’t know
	4. Prefer not to answer
13. **Have you had the flu vaccine in the last year?**
	1. Yes
	2. No