

Why is this survey important? In this survey we will ask you questions about COVID. Your answers to these questions are important to us because in some cases COVID has been linked to brain-related symptoms like fatigue, loss of taste and smell, and brain “fog”. We are interested in better understanding the link between COVID and these brain-related symptoms.

How long will this survey take to complete? 5 minutes or less.

1. Have you ever been diagnosed with or tested positive for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes</i>
Please specify the month and the year (MM/YYYY) of your three most recent COVID-19 infections.	[Provide free text field here]
2. Select symptoms you experienced with COVID-19. Please select all that apply.	<input type="checkbox"/> Bluish lips or face <input type="checkbox"/> Bluish or purple toes <input type="checkbox"/> Brain Fog or Memory Problems <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Confusion <input type="checkbox"/> Congestion or runny nose <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Exhaustion or excessive sleepiness <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Hallucinations <input type="checkbox"/> Headache <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Nausea <input type="checkbox"/> Shortness of breath or difficulty breathing <input type="checkbox"/> Sore throat <input type="checkbox"/> Vomiting <input type="checkbox"/> None of these symptoms

	3. Have you ever been hospitalized for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes:</i>		
	4. For how many days were you hospitalized?	
	5. Were you admitted to the ICU?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Were you intubated and put on a ventilator (breathing machine)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure
	7. At any time in the hospital, were you given supplemental oxygen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	8. Are you currently experiencing any longer term COVID-19 symptoms (lasting longer than 1 month)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes:</i>		
	Please check all that apply.	<input type="checkbox"/> Fatigue <input type="checkbox"/> Shortness of breath or labored breathing <input type="checkbox"/> Nausea <input type="checkbox"/> Headaches <input type="checkbox"/> Diarrhea <input type="checkbox"/> Confusion <input type="checkbox"/> Exhaustion or excessive sleepiness <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Congestion or runny nose <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Bluish lips or face <input type="checkbox"/> Bluish or purple toes <input type="checkbox"/> Hallucinations <input type="checkbox"/> Brain Fog or Memory Problems
<i>If no or I am not sure: This question should appear if someone answers no or not sure to question #6 above!</i>		
	9. Have you experienced any of the following flu-like symptoms since COVID-19 began?	<input type="checkbox"/> I did not experience any flu-like symptoms <input type="checkbox"/> Sore throat <input type="checkbox"/> Cough <input type="checkbox"/> Fever <input type="checkbox"/> Shortness of breath or labored breathing <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Headache

		<input type="checkbox"/> Diarrhea <input type="checkbox"/> Confusion <input type="checkbox"/> Exhaustion or excessive sleepiness <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Congestion or runny nose <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Bluish lips or face <input type="checkbox"/> Bluish or purple toes <input type="checkbox"/> Hallucinations
	10. Have you been tested for coronavirus antibodies? This typically requires a blood test.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure
	11. Have you been diagnosed with any of the following medical conditions? Please select all that apply.	
	12. High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	13. Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	14. Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	15. Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	16. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	17. COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	18. Other lung disease	<input type="checkbox"/> Yes

		<input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	19.Type 1 Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	20.Type 2 Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	21.Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	22.Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	23.Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	24.Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	25.Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	26.Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	27.Ulcerative Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	28.Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer

	29. Acid Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	30. Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not sure <input type="checkbox"/> I prefer not to answer
	31. Do you currently smoke tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I prefer not to answer
	<i>If no or I prefer not to answer</i>	
	32. Have you ever smoked tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I prefer not to answer
	33. Have you, or are you currently, participating in any COVID-19 vaccine trials? These would be official tests of new COVID-19 vaccines that would require at least one - and likely several - visits to a medical center to receive injections or nasal sprays to test new approaches to vaccinate against COVID-19.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
	34. Did you receive a COVID-19 vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes:</i>	
	35. What vaccine brand did you receive? Please select all that apply. We ask about your booster below.	<input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen/Johnson & Johnson <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Other
	36. When was the date of your first shot (or when is it scheduled (MM/YYYY))?	
	37. When was the date of your second shot (or when is it scheduled (DD/MM/YYYY))?	
	38. Have you received a COVID-19 booster shot?	<input type="checkbox"/> Yes No
	<i>If yes:</i>	
	1. What vaccine brand did you receive for your booster shot?	<input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen/Johnson & Johnson <input type="checkbox"/> AstraZeneca

	<input type="checkbox"/> Other. Please specify: _____
2. When was the date of your booster shoot (MM/YYYY)?	