

Title	Risk factors for long covid in previously hospitalised children using the ISARIC Global follow-up protocol: A prospective cohort study
Authors	Osmanov, Ismail M.;Spiridonova, Ekaterina;Bobkova, Polina;Gamirova, Aysylu;Shikhaleva, Anastasia;Andreeva, Margarita;Blyuss, Oleg;El-Taravi, Yasmin;DunnGalvin, Audrey;Comberiati, Pasquale;Peroni, Diego G.;Apfelbacher, Christian;Genuneit, Jon;Mazankova, Lyudmila;Miroshina, Alexandra;Chistyakova, Evgeniya;Samitova, Elmira;Borzakova, Svetlana;Bondarenko, Elena;Korsunskiy, Anatoliy A.;Konova, Irina;Wulf Hanson, Sarah;Carson, Gail;Sigfrid, Louise;Scott, Janet T.;Greenhawt, Matthew;Whittaker, Elizabeth A.;Garralda, Elena;Swann, Olivia V.;Buonsenso, Danilo;Nicholls, Dasha E.;Simpson, Frances;Jones, Christina;Semple, Malcolm G.;Warner, John O.;Vos, Theo;Olliaro, Piero;Munblit, Daniel
Publication date	2022-02
Original Citation	Osmanov, I. M., Spiridonova, E., Bobkova, P., Gamirova, A., Shikhaleva, A.,Andreeva, M., Blyuss, O., El-Taravi, Y., DunnGalvin, A., Comberiati, P., Peroni, D. G., Apfelbacher, C., Genuneit, J., Mazankova, L., Miroshina, A., Chistyakova, E., Samitova, E., Borzakova, S., Bondarenko, E., Korsunskiy, A. A., Konova, I., Wulf Hanson, S., Carson, G., Sigfrid, L., Scott, J. T., Greenhawt, M., Whittaker, E. A., Garralda, E., Swann, O. V., Buonsenso, D., Nicholls, D. E., Simpson, F., Jones, C., Semple, M. G., Warner, J. O., Vos, T., Olliaro, P., Munblit, D. and the Sechenov StopCOVID Research Team (2022) 'Risk factors for long covid in previously hospitalised children using the ISARIC Global follow-up protocol: A prospective cohort study', European Respiratory Journal, 59(2), 2101341 (11pp). doi: 10.1183/13993003.01341-2021
Type of publication	Article (peer-reviewed)
Link to publisher's version	10.1183/13993003.01341-2021
Rights	© 2022, the authors. This version is distributed under the terms of the Creative Commons Attribution Licence 4.0. - <a href="https://creativecommons.org/licenses/by/4.0/">https://creativecommons.org/licenses/by/4.0/</a>

Download date	2025-08-03 09:16:38
Item downloaded from	<a href="https://hdl.handle.net/10468/13623">https://hdl.handle.net/10468/13623</a>



**Table of contents**

Case Report Form (CRF) of Initial Survey: First Follow-Up Time Point version 1.0 .....2

Table S1. Categorisation of persistent symptoms at follow-up. .... 25

Table S2. Symptoms at the time of hospital admission.....25

Table S4. Parental perception of mood and behaviour changes in their children. ....29

Table S5. Parental-reported mood and behaviour changes due to Covid-19 and pandemic in their children, stratified by the the effect. ....30

Figure S1. The proportion of COVID-19 infected children who at various time points after discharge from hospital had one or more of the commonest continuing symptoms. Some children had more than one symptom. .... 31

Figure S2. Multivariable logistic regression model to identify pre-existing risk factors for post-COVID condition (using age as a continuous variable). Odds ratios and 95% CIs for presence of (A) any category of persistent symptoms at the time of follow-up and (B) two or more co-existing categories of persistent symptoms at the time of the follow-up. ....32

Figure S3. Multivariable logistic regression model to identify pre-existing risk factors for post-COVID condition (subgroup analyses in children ≥6 years of age). Odds ratios and 95% CIs for presence of (A) any category of persistent symptoms at the time of follow-up and (B) two or more co-existing categories of persistent symptoms at the time of the follow-up. ....33

## Case Report Form (CRF) of Initial Survey: First Follow-Up Time Point version 1.0

The questions were answered by the:

☐ Mother/female caregiver ☐ Father/male caregiver

Date you completed the survey (DD/MM/YYYY): [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_2\_][\_0\_][\_Y\_][\_Y\_]

What is your child's date of birth (DD/MM/YYYY): [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_Y\_][\_Y\_][\_Y\_][\_Y\_]

### 1. About your child

Sex/Gender: ☐ Male ☐ Female ☐ Prefer not to say

What is your child's estimated height (cm): \_\_\_\_\_ ☐ Not sure

What is your child's current estimated weight (kg): \_\_\_\_\_ ☐ Not sure

What was your child's estimated weight before Covid19 illness (kg): \_\_\_\_\_ ☐ Not sure

How many other members regularly live in your household, including yourself: [\_Number\_]

Does your child study in school/college/university? ☐ Yes ☐ No

How many years formal school education has your child had?\* [\_Number\_]

*\*including primary school (e.g. from around 6 years depending on country)*

Does your child study in kindergarten? ☐ Yes ☐ No

### 2. About your child's Covid-19 illness - all the questions relate to his/her health and wellbeing)

Approximately, what day did you first notice your child was experiencing symptoms of Covid-19? [\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_2\_][\_0\_][\_Y\_][\_Y\_]

How was your child diagnosed with Covid-19?

- ☐ Laboratory confirmed (positive PCR, antigen or Antibody test) ☐ Physician confirmed ☐ Test result is uncertain
- ☐ Not sure

Estimated date of your child's most recent positive SARS-CoV-2 /Covid-19 test:

[\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_2\_][\_0\_][\_Y\_][\_Y\_]

Indicate if ☐ PCR test ☐ Antibody test ☐ Unknown

Has your child been admitted to hospital due to Covid-19? ☐ Yes ☐ No

(If the answer is "no", please, move on to the section "3"; if the answer is "yes", please, proceed with the following questions)

- Roughly at what date was your child first admitted to hospital?

[\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_2\_][\_0\_][\_Y\_][\_Y\_]

- Roughly at what date was your child first discharged from hospital?

[\_D\_][\_D\_]/[\_M\_][\_M\_]/[\_2\_][\_0\_][\_Y\_][\_Y\_]

- If yes did they spent any time in the Paediatric Intensive Care Unit (PICU)? ☐ Yes ☐ No ☐ Not sure

- Has your child been admitted to hospital after the first acute Covid-19 illness? ☐ Yes ☐ No

If yes, how many times: [\_Number\_]

Name of hospital/hospitals: \_\_\_\_\_

If yes, specify reason/reasons: \_\_\_\_\_

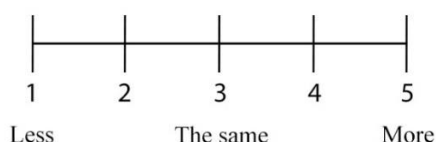
### 3. About your child's emotional wellbeing, social relationships and activities'

To answer the following questions, please **mark an X** on the lines below that shows your opinion on the question.

#### A. Compared to before your child's Covid-19 infection, how much is he/she now doing/experiencing the following

*If there are changes, please indicate whether you think these are due to the illness itself or to the Covid-19 pandemic*

##### Eating

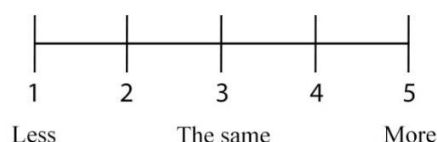


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Sleeping

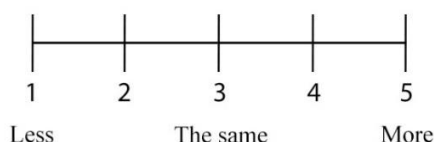


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Physical Activity

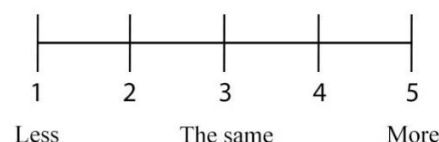


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Fatigue

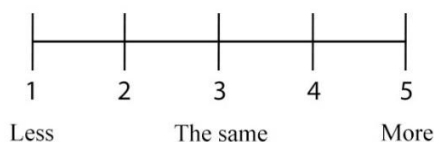


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Spending time with friends in-person

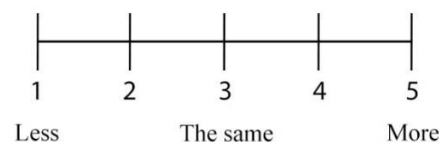


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Spending time with friends remotely (e.g., online, social media, texting)

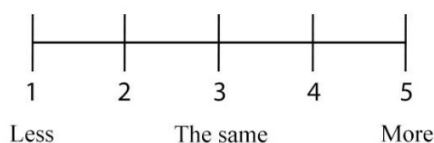


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Spending time watching TV, playing video/computer games, or using social media for educational purposes, including school/nursery work

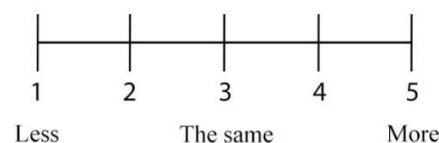


☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Spending time watching TV, playing video/computer games, or using social media for non-educational purposes,



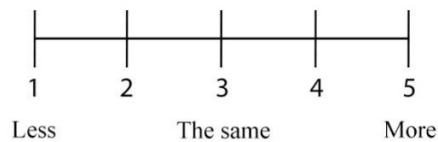
☐ Not known

*If there are changes, please indicate whether you think these are due to*

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

##### Spending time outside

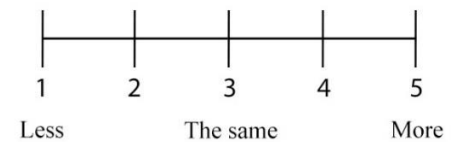
##### Attending school/nursery



☐ Not known

**If there are changes, please indicate whether you think these are due to**

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure



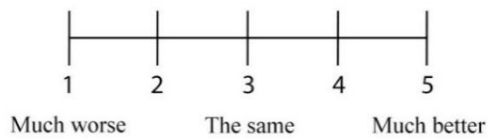
☐ My child has not been attending school/nursery before Covid-19 infection

**If there are changes, please indicate whether you think these are due to**

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

## B. Compared to before your child's Covid-19 illness: Have there been changes in your child's...

### ... CONNECTEDNESS with others...

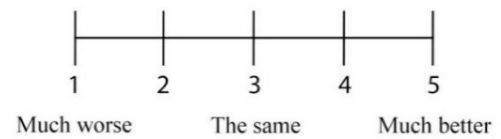


☐ Unsure

**If there are changes, please indicate whether you think these are due to**

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

### ...EMOTIONS?

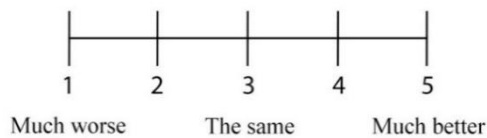


☐ Unsure

**If there are changes, please indicate whether you think these are due to**

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

### ...BEHAVIOUR?

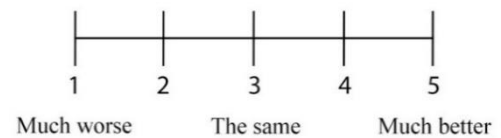


☐ Unsure

**If there are changes, please indicate whether you think these are due to**

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

### ...RELATIONSHIPS, in how they get on with others?



☐ Unsure

**If there are changes, please indicate whether you think these are due to**

☐ Illness itself ☐ Covid-19 pandemic ☐ Both ☐ Unsure

## C. Have you asked for help from a health professional because of Covid-19 illness consequences to your child's EMOTIONS, BEHAVIOUR OR RELATIONSHIPS?

☐ Yes ☐ No

If yes who did you ask for help from \_\_\_\_\_

## D. If you have replied MUCH WORSE to any of the options in question "B" OR YOU HAVE ASKED FOR HELP for these problems (question "C"), please, answer 3 of the following questions:

### 1. Do the difficulties upset or distress your child?

☐ Not at all ☐ Only a little ☐ Undecided ☐ Quite a lot ☐ A great deal

### 2. Do the difficulties interfere with your child's everyday life in the following areas?

Home Life	<input type="checkbox"/> Not at all <input type="checkbox"/> Only a little <input type="checkbox"/> Undecided <input type="checkbox"/> Quite a lot <input type="checkbox"/> A great deal
Friendships	<input type="checkbox"/> Not at all <input type="checkbox"/> Only a little <input type="checkbox"/> Undecided <input type="checkbox"/> Quite a lot <input type="checkbox"/> A great deal
Classroom Learning	<input type="checkbox"/> Not at all <input type="checkbox"/> Only a little <input type="checkbox"/> Undecided <input type="checkbox"/> Quite a lot <input type="checkbox"/> A great deal
Leisure Activities	<input type="checkbox"/> Not at all <input type="checkbox"/> Only a little <input type="checkbox"/> Undecided <input type="checkbox"/> Quite a lot <input type="checkbox"/> A great deal

### 3. Do these difficulties put a burden on you or the family as a whole?

☐ Not at all ☐ Only a little ☐ Undecided ☐ Quite a lot ☐ A great deal ☐ Unsure

## E. Do you live in Moscow or Moscow Oblast? ☐ Yes ☐ No

If No, what is the current situation in your town/city/region on lockdown measures?

**(you may select more than one answer)**

- ☐ Closing of child's school
- ☐ Closing of non-essential shops (shops and stores apart from food, doctors and drug stores)
- ☐ Closing of indoor places/venues
- ☐ Constraining meeting friends
- ☐ Closing of nurseries/kindergartens
- ☐ Cancellation/closing of recreational venues and activities
- ☐ Closing of outdoor recreational places
- ☐ Stay-at-home orders (not allowed to leave the house except for essential errands)

#### 4a. About your child's state of health prior to his/her Covid-19 illness

**Has your child been physician's diagnosed or received treatment/support for any of the following chronic medical conditions prior to the Covid-19 infection? (answer with a tick in the box)**

	Yes	No	Unknown
Prematurity ( <i>baby born &lt;37 weeks</i> )			
Neurological			
Neurodisability			
Heart diseases			
Respiratory diseases (not including asthma)			
Tuberculosis			
Asthma (doctor's diagnosed)			
Allergic rhinitis/hay fever			
Food allergy			
Atopic dermatitis/Eczema			
Other skin problems (not including eczema)			
Gut problems			
Haematology ( <i>blood diseases</i> )			
Oncology ( <i>cancer or other progressively enlarging or spreading tumor</i> )			
Immune system diseases (e.g. <i>primary immune deficiencies</i> )			
Genetic conditions			
Diabetes (if yes indicate type: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2)			
Other endocrine illness (not diabetes)			
Renal/Kidney problems			
Excessive weight and obesity			
Malnutrition ( <i>deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients</i> )			
Rheumatology (e.g. <i>arthritis, or inflammation of the joints</i> )			
Depression			
Anxiety			
HIV			
Other (please indicate)			

**Has your child ever been under Child and Adolescent Mental Health services before the Covid-19 pandemic?** ☐ Yes ☐ No ☐ Not sure

**Prior to Covid-19 infection, how was your child's physical health in general?**

- ☐ Very poor ☐ Poor ☐ Ok ☐ Good ☐ Very good

**If you ticked poor or very poor, please explain:**

**Prior to Covid-19 infection, how would you describe your child's mental health in general**

- ☐ Very poor ☐ Poor ☐ Ok ☐ Good ☐ Very good

**If you ticked poor or very poor, please explain:**

Have you requested help because of Covid-19 consequences to your child's physical health?

☐ Yes ☐ No ☐ Not sure

#### 4b. About your child's current health

Has your child felt feverish recently? ☐ Yes ☐ No ☐ Not sure

**If yes indicate when they felt feverish (tick all that apply)**

☐ Within the last 7 days ☐ >1-2 weeks ☐ >2-4 weeks ☐ >1-2 months ☐ >2-3 months ☐ >3-6 months

☐ >6 months ago

**If yes, what was the most likely cause of your child's most recent feverish illness?**

☐ Covid-19 ☐ Other respiratory infection (cough/cold/sore throat) ☐ TB ☐ Stomach infection

(diarrhea/vomiting) ☐ Urinary infection ☐ Other (specify): \_\_\_\_\_

☐ Unknown ☐ Prefer not to say

**If Covid-19, what was the estimated date of the most recent positive SARS-CoV-2 /Covid-19 test?**

[\_D\_] [\_D\_] / [\_M\_] [\_M\_] / [\_2\_] [\_0\_] [\_2\_] [\_Y\_] ]

Indicate if ☐ PCR test ☐ Antibody test ☐ Unknown

How much do you agree with the following statement?

**"My child has fully recovered from Covid-19"**

Please **mark an X** on the line below that shows your opinion on the question as of **TODAY**

0	1	2	3	4	5	6	7	8	9	10
Strongly disagree			Neutral				Strongly agree			

**5. Since having Covid-19, has your child been diagnosed with any of the following? (indicate the correct answer in the box provided)**

	YES	NO		YES	NO
Multisystem inflammatory syndrome			Shock / Toxic shock syndrome		
Pulmonary embolism (PE, "Clot in lung")			Coagulopathy (excessive bleeding or clotting)		
Kawasaki disease			Kidney problems		
Multisystem inflammatory syndrome (MIS-C/PIMS-TS)			Type 1 Diabetes		
Respiratory failure			Type 2 Diabetes		
Asthma			Intussusception		
Myocarditis (inflammation of the heart muscle)			Other condition (if yes specify):		



**6a. Within the last seven days, has your child had any of these symptoms, which were NOT present prior to their Covid-19 illness?  
If yes, please indicate below and the duration of the symptom/s:**

<b>Respiratory problems</b>	<b>Tick Yes or No</b>	<b>If yes, what is the duration of symptoms</b>
Nasal congestion / rhinorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Difficulty breathing /chest tightness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Pain on breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Persistent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<i>If yes, <input type="checkbox"/> dry cough <input type="checkbox"/> with phlegm</i>		
<b>Musculoskeletal problems</b>	<b>Tick Yes or No</b>	<b>If yes, what is the duration of symptoms</b>
Cannot fully move or control movement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Problems with balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Persistent muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge

		<input type="checkbox"/> Not sure
Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<b>Neurological problems</b>	<b>Tick Yes or No</b>	<b>If yes, what is the duration of symptoms</b>
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Dizziness/ light headedness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Fainting/ blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Problems seeing/blurred vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Disturbed smell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Loss of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Disturbed taste	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Loss of taste	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Tremor/shakiness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure

Tingling feeling/ "pins and needles"	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Seizures/fits	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Confusion/lack of concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Problems speaking or communicating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Insomnia ( <i>hard to fall asleep, hard to stay asleep</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Hypersomnia ( <i>excessive daytime sleepiness or prolonged nighttime sleep</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<b>Fatigue</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<b>Gastrointestinal problems</b>	<b>Tick Yes or No</b>	<b>If yes, what is the duration of symptoms</b>
Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Problems swallowing or chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months

		<input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Stomach/ abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Feeling nauseous	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<b>Cardiovascular problems</b>	<b>Tick Yes or No</b>	<b>If yes,</b> what is the duration of symptoms
Palpitations (heart racing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Variations in heart rate (tachycardia or bradycardia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<i>If yes, specify bleeding site:</i>		
<b>Genitourinary problems</b>	<b>Tick Yes or No</b>	<b>If yes,</b> what is the duration of symptoms
Urination problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Changes in menstruation, (if regular before Covid-19 illness)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure

Other problems	Tick Yes or No	If yes, what is the duration of symptoms
Bilateral conjunctivitis <i>If yes, <input type="checkbox"/> purulent <input type="checkbox"/> non-purulent</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Lumps or rashes (purple/pink) on toes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Skin rash <i>If yes, tick all body areas that apply:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face <input type="checkbox"/> Trunk (stomach or back) <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Buttocks <input type="checkbox"/> Toes <input type="checkbox"/> Fingers <input type="checkbox"/> Accompanied by itch
Hair loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
Hyperhidrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
<b>Other New Symptoms, if yes, specify all with their duration:</b>		<b>If yes, what is the duration of symptoms</b>
		<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
		<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure

**6b. Please report any symptoms that have been bothering your child since discharge that are not present today. Please specify the time of onset and duration of these symptoms**

Respiratory problems	Tick Yes or No	If yes, what was the time of onset
Nasal congestion / rhinorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Difficulty breathing /chest tightness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Pain on breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure

Persistent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> From the time of discharge  <input type="checkbox"/> Not sure</p> <p><b>If yes,</b> what was the duration of symptoms</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> Not sure</p>
<i>If yes, <input type="checkbox"/> dry cough <input type="checkbox"/> with phlegm</i>		
<b>Musculoskeletal problems</b>	<b>Tick Yes or No</b>	
Cannot fully move or control movement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> From the time of discharge  <input type="checkbox"/> Not sure</p> <p><b>If yes,</b> what was the duration of symptoms</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> Not sure</p>
Problems with balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> From the time of discharge  <input type="checkbox"/> Not sure</p> <p><b>If yes,</b> what was the duration of symptoms</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> Not sure</p>
Persistent muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> From the time of discharge  <input type="checkbox"/> Not sure</p> <p><b>If yes,</b> what was the duration of symptoms</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> Not sure</p>
Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <p><input type="checkbox"/> &lt; 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> &gt;2 -3 months <input type="checkbox"/> &gt;3-4 months <input type="checkbox"/> &gt;4-5 months  <input type="checkbox"/> &gt;5-6 months <input type="checkbox"/> &gt;6-7 months <input type="checkbox"/> &gt;7 -8 months <input type="checkbox"/> &gt;8-9 months <input type="checkbox"/> &gt;9 -10 months  <input type="checkbox"/> &gt;10-11 months <input type="checkbox"/> &gt;11 -12 months <input type="checkbox"/> &gt;12 months <input type="checkbox"/> From the time of discharge  <input type="checkbox"/> Not sure</p>



		<b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
<b>Neurological problems</b>	<b>Tick Yes or No</b>	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Dizziness/ light headedness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Fainting/ blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Problems seeing/blurred vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Disturbed smell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months



		<input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Loss of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Disturbed taste	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Loss of taste	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Tremor/shakiness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months

		<input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Tingling feeling/ “pins and needles”	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
		<p><b>If yes,</b> what was the duration of symptoms</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Seizures/fits	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
		<p><b>If yes,</b> what was the duration of symptoms</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Confusion/lack of concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
		<p><b>If yes,</b> what was the duration of symptoms</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Problems speaking or communicating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure
		<p><b>If yes,</b> what was the duration of symptoms</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Insomnia ( <i>hard to fall asleep, hard to stay asleep</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> what was the time of onset</p> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure

		<b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Hypersomnia ( <i>excessive daytime sleepiness or prolonged nighttime sleep</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
<b>Gastrointestinal problems</b>	<b>Tick Yes or No</b>	<b>If yes,</b> what was the time of onset
Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Problems swallowing or chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset

		<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Stomach/ abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Feeling nauseous	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months

		<input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
<b>Cardiovascular problems</b>	<b>Tick Yes or No</b>	<b>If yes,</b> what was the time of onset
Palpitations (heart racing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Variations in heart rate (tachycardia or bradycardia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes,</b> what was the time of onset <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes,</b> what was the duration of symptoms <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
<i>If yes, specify bleeding site:</i>		
<b>Genitourinary problems</b>	<b>Tick Yes or No</b>	<b>If yes,</b> what was the time of onset

Urination problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Changes in menstruation, (if regular before Covid-19 illness)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
<b>Other problems</b>	<b>Tick Yes or No</b>	<b>If yes, what was the time of onset</b>
Bilateral conjunctivitis <i>If yes, <input type="checkbox"/> purulent <input type="checkbox"/> non-purulent</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Lumps or rashes (purple/pink) on toes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months

		<input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Skin rash <i>If yes, tick all body areas that apply:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Face <input type="checkbox"/> Trunk (stomach or back) <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Buttocks <input type="checkbox"/> Toes <input type="checkbox"/> Fingers <input type="checkbox"/> Accompanied by itch
Hair loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
Hyperhidrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure
<b>Other New Symptoms, if yes, specify all with their onset and duration:</b>		<b>If yes, what was the time of onset</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> From the time of discharge <input type="checkbox"/> Not sure <b>If yes, what was the duration of symptoms</b> <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-2 months <input type="checkbox"/> >2 -3 months <input type="checkbox"/> >3-4 months <input type="checkbox"/> >4-5 months <input type="checkbox"/> >5-6 months <input type="checkbox"/> >6-7 months <input type="checkbox"/> >7 -8 months <input type="checkbox"/> >8-9 months <input type="checkbox"/> >9 -10 months <input type="checkbox"/> >10-11 months <input type="checkbox"/> >11 -12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Not sure

7. Your child's overall health status		
<p>We would like to know how good or bad your child's health was <b>BEFORE Covid-19</b> and how it is <b>TODAY</b></p> <p>This scale is numbered from 0 to 100% with <b>100% meaning the best health</b> you can imagine <b>0% means the worst health</b> you can imagine.</p> <p>Please indicate on the scale and <b>write the number in the box below each scale</b> to indicate how good or bad your child's health was <b>BEFORE Covid-19</b> and how it is <b>TODAY</b>.</p>	Best health	Best health
	100	100
	95	95
	90	90
	85	85
	80	80
	75	75
	70	70
	65	65
	60	60
	55	55
	50	50
	45	45
	40	40
	35	35
	30	30
	25	25
	20	20
	15	15
	10	10
	5	5
	0	0
	Before Covid-19	Today
	<input type="text"/>	<input type="text"/>



## 8. Vaccinations

**Has your child been vaccinated in accordance with the national vaccination schedule?**

☐ Yes, vaccinated up to date ☐ Yes, but some vaccines were missed ☐ No, I avoid vaccination for my child

**Please provide an approximate date of your child's latest vaccination?**

[\_D\_] [\_D\_] / [\_M\_] [\_M\_] / [\_2\_] [\_0\_] [\_Y\_] [\_Y\_]

Please, specify what was the vaccine: \_\_\_\_\_ ☐ I do not remember

**I trust information I receive about vaccines?**

☐ Not at all ☐ Only a little ☐ Undecided ☐ Quite a lot ☐ A great deal

**How confident are you in any of the childhood vaccines safety?**

☐ Not at all ☐ Only a little ☐ Undecided ☐ Quite a lot ☐ A great deal

**Has your child been vaccinated against Covid-19?** ☐ Yes ☐ No ☐ Not sure

If yes, how many times have they had the Covid-19 vaccine? [\_Number\_]

Estimated date of the last vaccine dose received: [\_D\_] [\_D\_] / [\_M\_] [\_M\_] / [\_2\_] [\_0\_] [\_2\_] [\_Y\_]

Which type of Covid-19 vaccine did they receive: ☐ AstraZeneca ☐ Pfizer-BioNTech

☐ Imperial ☐ Janssens ☐ Moderna's ☐ Sinopharm ☐ Sputnik V ☐ Other (name): \_\_\_\_\_ ☐ Not sure

**If no, would you like to vaccinate your child against Covid-19 in the future?** ☐ Yes ☐ No ☐ Not sure

**I trust information I receive about Covid-19 vaccination?**

☐ Not at all ☐ Only a little ☐ Undecided ☐ Quite a lot ☐ A great deal

**How confident are you in the safety of Covid-19 vaccinations?**

☐ Not at all ☐ Only a little ☐ Undecided ☐ Quite a lot ☐ A great deal

**What is your opinion of Russian-made vaccines against Covid-19?**

☐ Negative ☐ Neutral ☐ Positive ☐ Not sure

**What is your opinion of vaccines against Covid-19 produced abroad?**

☐ Negative ☐ Neutral ☐ Positive ☐ Not sure

## 9. Some questions about you

During your child's illness, have you often been in a bad mood, depressed or feeling hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During your child's illness, did you often feel that everything was difficult, and you did not want to do anything?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During your child's illness, did you often feel persistent fatigue for no reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did your child's illness often make you feel nervous, anxious or extremely stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did your child's illness often leave you unable to calm down or have you often been unable to calm or control your worries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Due to your child's illness, have you often experienced fear, as if something terrible were about to happen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Due to your child's illness, have you had to face aggressive or prejudiced attitudes from others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you receive enough help and support during your child's illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**10. Please let us know of any further comments about the child’s illness, the pandemic, lockdown and/or any sequelae.**

**11. End of survey**

**Thank you for your time!**

**Table S1.** Categorisation of persistent symptoms at follow-up.

Symptom category	Persistent symptoms included
Musculoskeletal	joint pain or swelling OR persistent muscle pain
Cardiovascular	variations in heart rate OR palpitations
Respiratory	difficulty breathing/chest tightness OR pain on breathing OR persistent cough
Neurological	cannot fully move or control movement OR problems with balance OR confusion/lack of concentration OR problems speaking or communicating OR seizures/fits OR tingling feeling/ 'pins and needles' OR tremor/shakiness OR dizziness/light headedness OR fainting/ blackouts
Dermatological	skin rash OR lumps or rashes (purple/pink) on toes OR hair loss
Gastrointestinal	constipation OR diarrhea OR feeling nauseous OR stomach/ abdominal pain OR vomiting
Sensory	disturbed smell OR disturbed taste OR loss of smell OR loss of taste
Sleep	hypersomnia OR insomnia
Fatigue	fatigue

**Table S2.** Symptoms at the time of hospital admission.

Characteristics	Results
History of fever	427/511 (83.6%)
Cough	284/510 (55.7%)
Fatigue	197/506 (38.9%)
Rhinorrhoea	278/512 (54.3%)
Shortness of breath	77/513 (15%)
Disturbed smell or loss of smell	64/456 (14%)
Sore throat	67/487 (13.8%)
Lymphadenopathy	52/512 (10.2%)
Headache	40/465 (8.6%)
Diarrhoea	43/511 (8.4%)
Skin rash	41/512 (8%)
Wheezing	39/512 (7.6%)
Vomiting / Nausea	32/512 (6.2%)
Chest pain	28/464 (6%)
Abdominal pain	27/489 (5.5%)
Disturbed taste or Loss of taste	16/456 (3.5%)
Muscle aches	14/463 (3%)
Conjunctivitis	10/512 (2%)
Joint pain	5/461 (1.1%)
Ear pain	3/463 (0.6%)
Seizures	3/512 (0.6%)
Bleeding	3/512 (0.6%)
Lower chest wall indrawing	3/512 (0.6%)
Confusion	2/511 (0.4%)

The differing denominators used indicate missing data.

**Table S3.** Most commonly used treatments during the hospital stay.

Characteristics	Total
Antiviral or COVID-19 targeted agent	394/512 (77.0%)
Antibiotics	380/513 (74.1%)
Mucolytics	188/513 (36.7%)
Arbidol	133/512 (26%)
Antifungal agent	25/513 (4.9%)
Corticosteroid	20/513 (3.9%)
Heparin	17/513 (3.3%)

The differing denominators used indicate missing data.

**Table S4.** Symptoms reported at the time of the follow-up interview and symptom duration (in months).

Current symptom	Total number of patients with the symptom	Total number of patients with the persistent symptom	< 1	1-2	> 2-3	> 3-4	> 4-5	> 5-6	> 6-7	> 7-8	> 8-9	> 9-10	From the time of discharge
Fatigue	63/498 (12.65%)	53/496 (10.69%)	5/496 (1.01%)	1/496 (0.2%)	0/496 (0%)	1/496 (0.2%)	1/496 (0.2%)	4/496 (0.81%)	1/496 (0.2%)	2/496 (0.4%)	1/496 (0.2%)	0/496 (0%)	45/496 (9.07%)
Nasal congestion/ rhinorrhea	43/505(8.51%)	10/505 (1.98%)	29/505 (5.74 %)	2/505 (0.4%)	1/505 (0.2 %)	1/505 (0.2%)	0/505 (0%)	0/505 (0%)	0/505 (0%)	0/505 (0%)	0/505 (0%)	0/505 (0%)	10/505 (1.98 %)
Insomnia	32/501 (6.39%)	26/501 (5.19%)	2/501 (0.4%)	2/501 (0.4%)	1/501 (0.2%)	0/501 (0%)	1/501 (0.2%)	2/501 (0.4%)	1/501 (0.2%)	1/501 (0.2%)	0/501 (0%)	0/501 (0%)	22/501 (4.39%)
Disturbed smell	26/468 (5.56%)	22/467 (4.71%)	0/467 (0%)	2/467 (0.43%)	1/467 (0.21%)	0/467 (0%)	0/467 (0%)	3/467 (0.64%)	0/467 (0%)	2/467 (0.43%)	0/467 (0%)	0/467 (0%)	17/467 (3.64%)
Headache	24/488(4.92%)	17/486 (3.5%)	4/486 (0.82%)	0/486 (0%)	1/486 (0.21%)	0/486 (0%)	0/486 (0%)	1/486 (0.21%)	0/486 (0%)	0/486 (0%)	0/486 (0%)	0/486 (0%)	16/486 (3.29%)
Disturbed taste	18/468 (3.85%)	16/468 (3.42%)	0/468 (0%)	1/468 (0.21%)	1/468 (0.21%)	0/468 (0%)	0/468 (0%)	2/468 (0.43%)	0/468 (0%)	2/468 (0.43%)	0/468 (0%)	0/468 (0%)	12/468 (2.56%)
Hyperhidrosis	17/502(3.39%)	13/502 (2.59%)	1/502 (0.2%)	2/502 (0.4%)	0/502 (0%)	1/502 (0.2%)	0/502 (0%)	0/502 (0%)	0/502 (0%)	1/502 (0.2%)	0/502 (0%)	0/502 (0%)	12/502 (2.39%)
Persistent cough	17/503 (3.38%)	5/503 (0.99%)	9/503 (1.79%)	3/503 (0.6%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	5/503 (0.99%)
Hypersomnia	16/501 (3.19%)	15/501 (2.99%)	0/501 (0%)	0/501 (0%)	0/501 (0%)	1/501 (0.2%)	0/501 (0%)	1/501 (0.2%)	1/501 (0.2%)	1/501 (0.2%)	1/501 (0.2%)	0/501 (0%)	11/501 (2.2%)
Poor appetite	15/500 (3%)	12/500 (2.4%)	2/500 (0.4%)	0/500 (0%)	1/500 (0.2%)	0/500 (0%)	0/500 (0%)	1/500 (0.2%)	0/500 (0%)	1/500 (0.2%)	1/500 (0.2%)	0/500 (0%)	9/500 (1.8%)
Skin rash	13/497 (2.62%)	8/497 (1.61%)	3/497 (0.6%)	0/497 (0%)	1/497 (0.2%)	0/497 (0%)	1/497 (0.2%)	2/497 (0.4%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	6/497 (1.21%)
Diarrhea	13/499 (2.61%)	10/499 (2%)	1/499 (0.2%)	0/499 (0%)	1/499 (0.2%)	0/499 (0%)	1/499 (0.2%)	0/499 (0%)	0/499 (0%)	1/499 (0.2%)	0/499 (0%)	0/499 (0%)	9/499 (1.8%)
Stomach/ abdominal pain	13/499 (2.61%)	10/499 (2%)	1/499 (0.2%)	1/499 (0.2%)	1/499 (0.2%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	1/499 (0.2%)	0/499 (0%)	0/499 (0%)	9/499 (1.8%)
Problems seeing/ blurred vision	12/480 (2.5%)	10/479 (2.09%)	0/479 (0%)	0/479 (0%)	1/479 (0.21%)	0/479 (0%)	0/479 (0%)	1/479 (0.21%)	1/479 (0.21%)	0/479 (0%)	0/479 (0%)	0/479 (0%)	8/479 (1.67%)
Hair loss	12/501 (2.4%)	9/501 (1.8%)	0/501 (0%)	1/501 (0.2%)	2/501 (0.4%)	0/501 (0%)	0/501 (0%)	1/501 (0.2%)	1/501 (0.2%)	1/501 (0.2%)	0/501 (0%)	0/501 (0%)	6/501 (1.2%)
Dizziness/ light headedness	10/486 (2.06%)	5/484 (1.03%)	2/484 (0.41%)	1/484 (0.21%)	0/484 (0%)	0/484 (0%)	0/484 (0%)	0/484 (0%)	0/484 (0%)	0/484 (0%)	0/484 (0%)	0/484 (0%)	5/484 (1.03%)
Joint pain or swelling	10/493 (2.03%)	6/492 (1.22%)	1/492 (0.2%)	2/492 (0.41%)	0/492 (0%)	0/492 (0%)	0/492 (0%)	0/492 (0%)	0/492 (0%)	1/492 (0.2%)	0/492 (0%)	0/492 (0%)	5/492 (1.02%)
Variations in heart rate	10/494 (2.02%)	6/493 (1.22%)	0/493 (0%)	0/493 (0%)	1/493 (0.2%)	0/493 (0%)	0/493 (0%)	0/493 (0%)	0/493 (0%)	1/493 (0.2%)	0/493 (0%)	0/493 (0%)	5/493 (1.01%)
Constipation	9/500 (1.8%)	8/500 (1.6%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	1/500 (0.2%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	8/500 (1.6%)
Loss of smell	8/468 (1.71%)	7/468 (1.5%)	0/468 (0%)	1/468 (0.21%)	0/468 (0%)	0/468 (0%)	0/468 (0%)	0/468 (0%)	0/468 (0%)	0/468 (0%)	0/468 (0%)	0/468 (0%)	7/468 (1.5%)

Difficulty breathing /chest tightness	8/503 (1.59%)	7/503 (1.39%)	1/503 (0.2 %)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	1/503 (0.2 %)	0/503 (0%)	0/503 (0%)	0/503 (0%)	0/503 (0%)	6/503 (1.19 %)
Palpitations	7/472(1.48%)	5/471 (1.06%)	0/471 (0%)	0/471 (0%)	1/471 (0.21%)	0/471 (0%)	0/471 (0%)	0/471 (0%)	0/471 (0%)	1/471 (0.21%)	0/471 (0%)	0/471 (0%)	4/471 (0.85%)
Feeling nauseous	7/500 (1.4%)	6/500 (1.2%)	1/500 (0.2%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	1/500 (0.2%)	1/500 (0.2%)	0/500 (0%)	0/500 (0%)	4/500 (0.8%)
Chest pain	6/487(1.23%)	3/487 (0.62%)	2/487 (0.41 %)	0/487 (0%)	1/487 (0.21 %)	0/487 (0%)	0/487 (0%)	0/487 (0%)	0/487 (0%)	0/487 (0%)	0/487 (0%)	0/487 (0%)	3/487 (0.62 %)
Persistent muscle pain	6/491(1.22%)	4/490 (0.82%)	1/490 (0.2%)	0/490 (0%)	0/490 (0%)	0/490 (0%)	0/490 (0%)	0/490 (0%)	0/490 (0%)	1/490 (0.2%)	0/490 (0%)	0/490 (0%)	3/490 (0.61%)
Problems with balance	6/496(1.21%)	2/494 (0.4%)	1/494 (0.2%)	1/494 (0.2%)	0/494 (0%)	0/494 (0%)	0/494 (0%)	0/494 (0%)	0/494 (0%)	0/494 (0%)	0/494 (0%)	0/494 (0%)	2/494 (0.4%)
Urination problems	4/496 (0.81%)	3/496 (0.6%)	1/496 (0.2%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	1/496 (0.2%)	2/496 (0.4%)
Vomiting	4/500 (0.8%)	4/500 (0.8%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	1/500 (0.2%)	0/500 (0%)	3/500 (0.6%)
Confusion/ lack of concentration	3/486 (0.62%)	2/486 (0.41%)	0/486 (0%)	0/486 (0%)	0/486 (0%)	0/486 (0%)	1/486 (0.21%)	1/486 (0.21%)	0/486 (0%)	0/486 (0%)	0/486 (0%)	0/486 (0%)	1/486 (0.21%)
Pain on breathing	3/488(0.61%)	2/488 (0.41%)	0/488 (0%)	0/488 (0%)	1/488 (0.2 %)	0/488 (0%)	0/488 (0%)	0/488 (0%)	0/488 (0%)	0/488 (0%)	0/488 (0%)	0/488 (0%)	2/488 (0.41%)
Cannot fully move or control movement	3/499(0.6%)	2/499 (0.4%)	0/499 (0%)	1/499 (0.2%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	2/499 (0.4%)
Tremor/ shakiness	3/500 (0.6%)	3/500 (0.6%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	3/500 (0.6%)
Bleeding	3/497 (0.6%)	1/497 (0.2%)	0/497 (0%)	1/497 (0.2%)	1/497 (0.2%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	0/497 (0%)	1/497 (0.2%)
Changes in menstruation	3/501 (0.6%)	3/501 (0.6%)	0/501 (0%)	0/501 (0%)	0/501 (0%)	0/501 (0%)	0/501 (0%)	0/501 (0%)	1/501 (0.2%)	0/501 (0%)	0/501 (0%)	0/501 (0%)	2/501 (0.4%)
Loss of taste	2/469(0.43%)	2/469 (0.43%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	0/469 (0%)	2/469 (0.43%)
Tingling feeling/ “pins and needles“	2/472 (0.42%)	2/472 (0.42%)	0/472 (0%)	1/472 (0.21%)	0/472 (0%)	0/472 (0%)	0/472 (0%)	0/472 (0%)	1/472 (0.21%)	0/472 (0%)	0/472 (0%)	0/472 (0%)	0/472 (0%)
Weight loss	2/500 (0.4%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	1/500 (0.2%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)	0/500 (0%)
Problems swallowing or chewing	2/499 (0.4%)	1/499 (0.2%)	1/499 (0.2%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	0/499 (0%)	1/499 (0.2%)
Bilateral conjunctivitis	2/496 (0.4%)	2/496 (0.4%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	0/496 (0%)	2/496 (0.4%)
Seizures/fits	1/498 (0.2%)	0/498 (0%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)	0/498 (NaN%)
Lumps or rashes	1/495 (0.2%)	1/495 (0.2%)	0/495	0/495	0/495	0/495	0/495	0/495	0/495	0/495	0/495	0/495	1/495 (0.2%)

(purple/pink) on toes	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)	(0%)
Problems speaking or communicating	1/489 (0.2%)	1/489 (0.2%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	0/489 (0%)	1/489 (0.2%)
Fainting/blackouts	0/497 (0%)	0/497 (0%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)	0/497 (NaN%)

The differing denominators used indicate missing data.

**Table S4.** Parental perception of mood and behaviour changes in their children.

Characteristic	Likert scale response							Reasons of changes			
	1 (less)	2	3 (the same)	4	5 (more)	Not known	Other	Illness itself	Covid-19 pandemic	Both	Unsure
Eating	14 (2.7%)	23 (4.5%)	445 (86.4%)	9 (1.7%)	10 (1.9%)	3 (0.6%)	11 (2.1%)	28 (49.1%)	4 (7%)	2 (3.5%)	23 (40.4%)
Sleeping	15 (2.9%)	23 (4.5%)	447 (86.8%)	5 (1%)	11 (2.1%)	4 (0.8%)	10 (1.9%)	28 (52.8%)	7 (13.2%)	4 (7.5%)	14 (26.4%)
Physical activity	27 (5.2%)	33 (6.4%)	429 (83.3%)	9 (1.7%)	4 (0.8%)	3 (0.6%)	10 (1.9%)	26 (37.7%)	22 (31.9%)	5 (7.2%)	16 (23.2%)
Fatigue	3 (0.6%)	11 (2.1%)	400 (77.8%)	39 (7.6%)	48 (9.3%)	4 (0.8%)	9 (1.8%)	53 (53%)	11 (11%)	16 (16%)	20 (20%)
Spending time with friends in-person	31 (6.2%)	27 (5.4%)	392 (78.1%)	19 (3.8%)	6 (1.2%)	17 (3.4%)	10 (2%)	4 (4.8%)	66 (78.6%)	7 (8.3%)	7 (8.3%)
Spending time with friends remotely	1 (0.2%)	5 (1%)	397 (80.4%)	27 (5.5%)	37 (7.5%)	24 (4.9%)	3 (0.6%)	2 (2.8%)	58 (81.7%)	7 (9.9%)	4 (5.6%)
Spending time watching TV, playing video/computer games, or using social media for educational purposes, including school/nursery work	2 (0.4%)	2 (0.4%)	360 (71.9%)	42 (8.4%)	68 (13.6%)	23 (4.6%)	4 (0.8%)	2 (1.8%)	105 (92.9%)	2 (1.8%)	4 (3.5%)
Spending time watching TV, playing video/computer games, or using social media for non-educational purposes	4 (0.8%)	9 (1.8%)	408 (81.8%)	20 (4%)	28 (5.6%)	24 (4.8%)	6 (1.2%)	2 (3.4%)	44 (75.9%)	2 (3.4%)	10 (17.2%)
Spending time outside	36 (7.1%)	39 (7.7%)	364 (71.5%)	35 (6.9%)	18 (3.5%)	6 (1.2%)	11 (2.2%)	5 (4.1%)	89 (73%)	11 (9%)	17 (13.9%)
Attending school/nursery	29 (5.7%)	7 (1.4%)	313 (61.9%)	4 (0.8%)	36 (7.1%)	102 (20.2%)	15 (3%)	3 (3.7%)	65 (79.3%)	2 (2.4%)	12 (14.6%)
Connectedness	4 (0.8%)	20 (4%)	456 (91%)	4 (0.8%)	1 (0.2%)	13 (2.6%)	3 (0.6%)	3 (10.7%)	14 (50%)	5 (17.9%)	6 (21.4%)
Emotions	11 (2.2%)	57 (11.2%)	411 (80.4%)	11 (2.2%)	3 (0.6%)	5 (1%)	13 (2.5%)	24 (29.6%)	16 (19.8%)	10 (12.3%)	31 (38.3%)
Behaviour	5 (1%)	37 (7.2%)	438 (85.5%)	8 (1.6%)	3 (0.6%)	5 (1%)	16 (3.1%)	16 (28.1%)	7 (12.3%)	6 (10.5%)	28 (49.1%)
Relationships	1 (0.2%)	14 (2.8%)	481 (95.2%)	1 (0.2%)	0 (0%)	5 (1%)	3 (0.6%)	7 (46.7%)	2 (13.3%)	3 (20%)	3 (20%)

The differing denominators used indicate missing data.

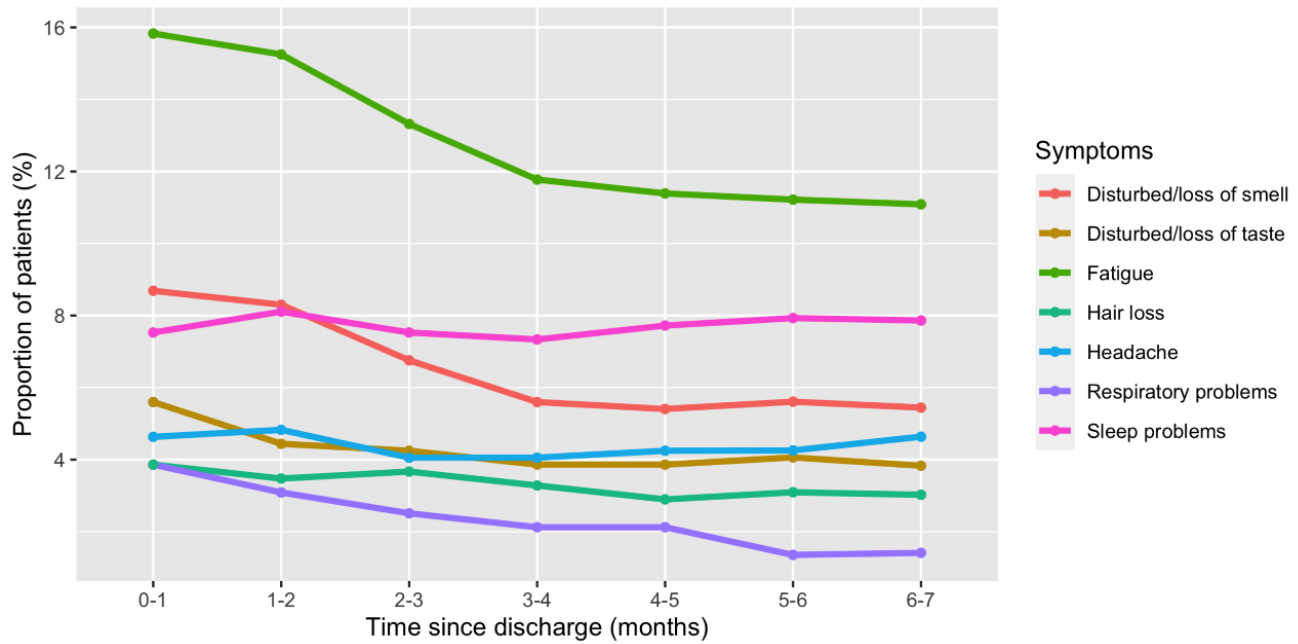
**Table S5.** Parental-reported mood and behaviour changes due to Covid-19 and pandemic in their children, stratified by the the effect.

Characteristic	Caused by illness itself		Caused by Covid-19 pandemic	
	<i>Less</i>	<i>More</i>	<i>Less</i>	<i>More</i>
Eating	23/512 (4.5%)	4/512 (0.8%)	0 (0%)	4/512 (0.8%)
Sleeping	18/511 (3.5%)	10/511 (2%)	6/511 (1.2%)	1/511 (0.2%)
Physical activity	24/512 (4.7%)	2/512 (0.4%)	19/512 (3.7%)	3/512 (0.6%)
Fatigue	7/510 (1.4%)	46/510 (9%)	1/510 (0.2%)	10/510 (2%)
Spending time with friends in-person	2/485 (0.4%)	2/485 (0.4%)	47/485 (9.7%)	19/485 (3.9%)
Spending time with friends remotely	2/470 (0.4%)	0 (0%)	2/470 (0.4%)	55/470 (11.7%)
Spending time watching TV, playing video/computer games, or using social media for educational purposes, including school/nursery work	1/478 (0.2%)	1/478 (0.2%)	0 (0%)	105/478 (22%)
Spending time watching TV, playing video/computer games, or using social media for non-educational purposes	1/475 (0.2%)	1/475 (0.2%)	3/475 (0.6%)	41/475 (8.6%)
Spending time outside	5/503 (1%)	0 (0%)	49/503 (9.7%)	39/503 (7.8%)
Attending school/nursery	2/404 (0.5%)	1/404 (0.3%)	29/404 (7.2%)	36/404 (8.9%)
Connectedness	2/488 (0.4%)	1/488 (0.2%)	13/488 (2.7%)	1/488 (0.2%)
Emotions	22/511 (4.3%)	2/511 (0.4%)	13/511 (2.5%)	2/511 (0.4%)
Behaviour	14/506 (2.8%)	1/506 (0.2%)	0 (0%)	7/506 (1.4%)
Relationships	7/500 (1.4%)	0 (0%)	2/500 (0.4%)	0 (0%)

The differing denominators used indicate missing data.

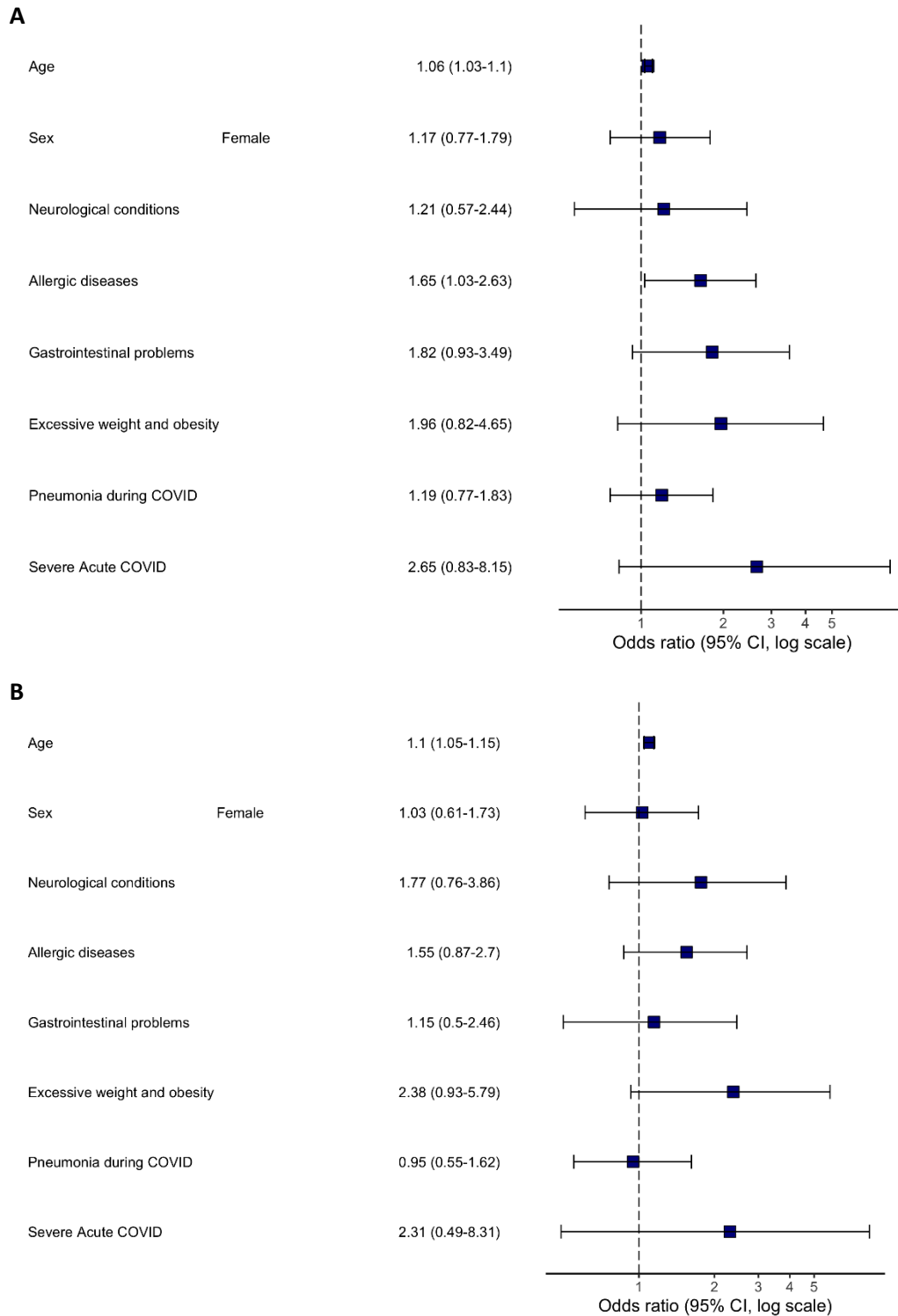


**Figure S1.** The proportion of COVID-19 infected children who at various time points after discharge from hospital had one or more of the commonest continuing symptoms. Some children had more than one symptom.



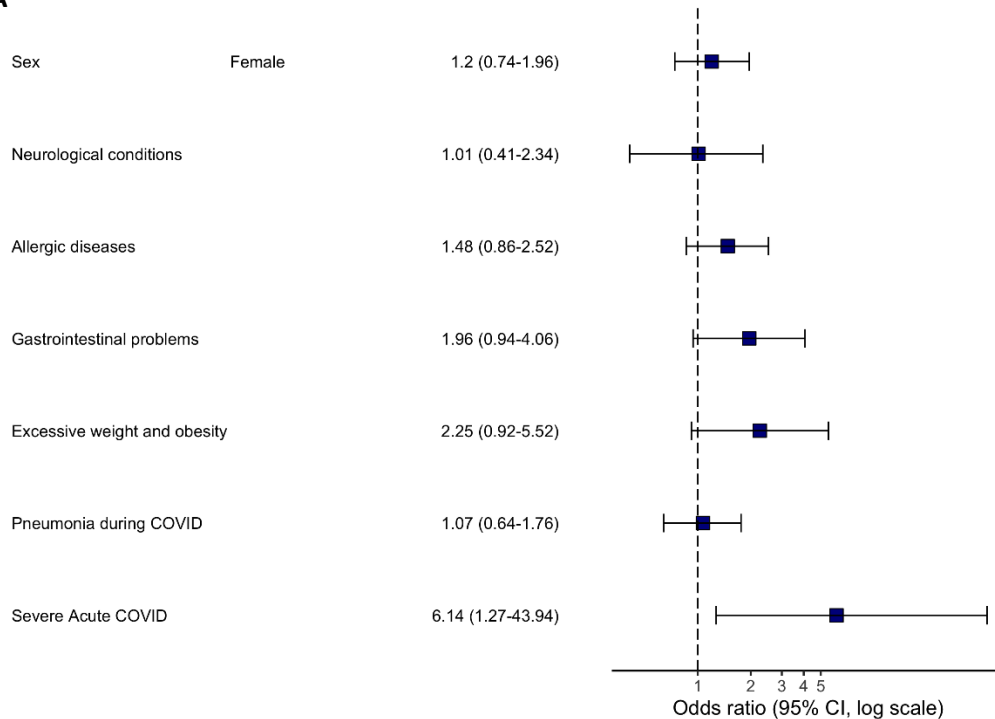
The prevalence was calculated based on responses to the following questions: “Within the last seven days, has your child had any of these symptoms, which were NOT present prior to their Covid-19 illness? (If yes, please indicate below and the duration of the symptom/s) and “Please report any symptoms that have been bothering your child since discharge that are not present today. Please specify the time of onset and duration of these symptoms.”

**Figure S2.** Multivariable logistic regression model to identify pre-existing risk factors for post-COVID condition (using age as a continuous variable). Odds ratios and 95% CIs for presence of (A) any category of persistent symptoms at the time of follow-up and (B) two or more co-existing categories of persistent symptoms at the time of the follow-up. Neurological conditions include “neurological disorders” and/or “neurodisability”. Abbreviation: CI, confidence interval.



**Figure S3.** Multivariable logistic regression model to identify pre-existing risk factors for post-COVID condition (subgroup analyses in children  $\geq 6$  years of age). Odds ratios and 95% CIs for presence of (A) any category of persistent symptoms at the time of follow-up and (B) two or more co-existing categories of persistent symptoms at the time of the follow-up. Neurological conditions include “neurological disorders” and/or “neurodisability”. Abbreviation: CI, confidence interval.

**A**



**B**

