

Long COVID Symptoms Record

Date:

Name:

Age:

Gender: F M

Occupation:

Address:

Phone:

Email:

Physician:

Specialist(s):

PRE-COVID-19 HEALTH HISTORY

Pre-existing health issue(s): Y N

If yes, list health issue(s):

- 1.
- 2.
- 3.
- 4.
- 5.

Medications:

- 1.
- 2.
- 3.
- 4.
- 5.

COVID ILLNESS HISTORY

Date of onset of COVID-19: _____ Positive COVID-19 test? Y N

Vaccinated before contracting COVID? Y N

If yes, name of 1st vaccine:

Date:

2nd vaccine:

Date:

Antibody test? Y N If yes, date and results:

Hospitalization? Y N If yes, dates in hospital: From _____ To _____

Were you given supplemental oxygen? Y N Were you in the Intensive Care Unit? Y N

Health issues addressed in hospital:

INSTRUCTIONS FOR RECORDING SYMPTOMS & SEVERITY

Recording your Long COVID symptoms & severity once per week, or every two weeks, will help you monitor your progress to wellness. Share copies of these records with your healthcare providers.

- Print and complete a copy of the symptom chart each week. If you miss a week, or several weeks, don't worry. It's better not to guess.
- **Week 0:** The first chart will be your baseline. Mark down each pre-COVID symptom severity that applies. For example, prior to falling ill with COVID you may have had chronic insomnia, anxiety or constipation.
- **Week 1** is the end of the first week you had COVID symptoms. Count calendar weeks from that Week 1.
- **Week 2 and forward:** On the weekend, mark the severity of each symptom from 0-5. Record **the worst you felt that week**. If you don't remember, record how you feel **that day**.

Week _____

Date: _____, 202__

Patient name:

Healthcare Practitioner:

Self-rated

Interview

Symptoms & Severity Place a check mark in the appropriate column	New this week	N/A	Very Mild	Mild	Moderate	Severe	Very Severe
		0	1	2	3	4	5
Fatigue							
Fever ≥ 98.8 F (37 C)							
Flushes/Sweats							
Chills							
Dizziness/vertigo/balance issue							
Cough (dry)							
Cough (with mucus)							
Shortness of breath							
Heart palpitations							
Tightness or burning in chest							
Tachycardia (rapid heartbeat)							
Blurred vision							
Sensitivity to light							
Inability to taste							
Inability to smell							
Sensitivity to noise							
ringing in ears/tinnitus							
Speech/language issues							
Brain fog/cognitive dysfunction							
Insomnia							
Memory issues							
Difficulty concentrating							
Muscle aches							
Joint pain							
Nerve pain or tingling (Neuralgia)							
Skin rash							
Menstruation changes							
Bladder control issues							
Constipation							
Diarrhea							
Other symptoms (see list on next page)							
Total # of symptoms this week:	Symptoms get worse after physical activity? <input type="checkbox"/> Y <input type="checkbox"/> N						
Therapy(s) this week:	Symptoms get worse due to mental activity? <input type="checkbox"/> Y <input type="checkbox"/> N						
	Change in medication this week: <input type="checkbox"/> Y Describe below:						
How do you feel today, in general? <input type="checkbox"/> ≤ 25% <input type="checkbox"/> 25% - 50%							
<input type="checkbox"/> 50% - 75% <input type="checkbox"/> 75% - 99% <input type="checkbox"/> 100% (Pre-COVID normal)							
Were you able to work or do your normal activities this week? <input type="checkbox"/> Yes <input type="checkbox"/> Yes, but reduced hours <input type="checkbox"/> No							
If no, check the reason(s): <input type="checkbox"/> Fatigue <input type="checkbox"/> Cognitive issues <input type="checkbox"/> On sick leave <input type="checkbox"/> On disability <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____							

Other Long COVID Symptoms

Emotion and Mood

Anxiety
Irritability
Depression
Tearfulness
Apathy

Systemic

Weakness
Skin sensations
Heat intolerance
Low temperature

Nose/Throat/ Lungs/Eye/Ear/Face

Runny nose
Sinus issues

Sore throat
Difficulty swallowing

Excessive coughing
Coughing up blood
Rattling of breath

Vision loss
Double vision
Dry or itchy eyes
Eye pressure or pain
Bloodshot eyes

Ear pain
Hearing loss
Facial pressure/numbness
Facial paralysis

OTHER

Reproductive/Genitourinary/Endocrine

Extreme thirst
Early menopause
Post-menopausal bleeding
Sexual Dysfunction

Musculoskeletal

Muscle spasms
Bone ache or burning
Stiff neck

Gastrointestinal

Loss of appetite
Nausea
Abdominal pain

Cardiovascular

Bradycardia (slow heart rate)
Fainting
Inflamed or bulging veins

Dermatologic/Immunologic/Autoimmune

Itchy skin
Peeling skin
Petechia (red or purple spots on skin)
Dermatographia (raised welts from scratching)

New allergy(s)
Heightened reaction to pre-existing allergy(s)
New anaphylaxis reaction

Shingles
Brittle or discolored nails
Discolored or swollen toes (COVID Toe)

OTHER