Appendix 2

**Questionnaire for COVID-19 patients**

**Demographic characteristics**

1. Number
2. Name
3. Sex: male/female
4. Height(cm)
5. Weight(kg)

**Symptomatic features**

1. Date of onset: y-m-d, symptomatic or asymptomatic(Nucleic acid test positive only)
2. Fever: yes/no, if yes
3. Fever type: persistent/intermittent, if persistent

 Date of symptom emerges: y-m-d

 Highest temperature: ℃

 Date of Highest temperature: y-m-d

 Date of symptom relief: y-m-d

1. If intermittent,

 The main period of fever: morning/afternoon/evening

 Date of fever 1: y-m-d, Highest temperature: ℃, Date of fever relief 2: y-m-d

 Date of fever 2: y-m-d, Highest temperature: ℃, Date of fever relief 2: y-m-d

 Date of fever 3: y-m-d, Highest temperature: ℃, Date of fever relief 3: y-m-d

1. Cough: yes/no, if yes

 Date of symptom emerges: y-m-d

 Date of the worst symptom: y-m-d

 Cough type: dry cough/sputum(color)

Date of symptom relief: y-m-d

1. Fatigue: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of the worst symptom: y-m-d

Date of symptom relief: y-m-d

1. Dyspnea: yes/no, if yes

 Date of symptom emerges: y-m-d

 mMRC grade at dyspnea onset:

Date of the worst symptom: y-m-d

Worst mMRC grade:

Date of symptom relief: y-m-d

mMRC grade at dyspnea relief:

1. Sore throat: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Rhinorrhea: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Myalgia or arthralgia: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Dysosmia: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Dysgeusia: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Nausea or vomiting: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Loss of appetite: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Diarrhea: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Headache: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Dizziness: yes/no, if yes

 Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Skin change: yes/no, if yes

Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Other symptoms: yes/no, if yes

Date of symptom emerges: y-m-d

Date of symptom relief: y-m-d

1. Whether chest CT examination was performed before admission: yes/no
2. Date of first positive Nucleic acid test: y-m-d
3. Date of first negative Nucleic acid test: y-m-d

**Personal history**

1. History of smoking: yes/no, if yes

Duration of smoking: years

How many cigarettes per day:

Duration of quitting: years

1. History of drinking: yes/no, if yes

Duration of drinking: years

Type of alcohol: wine/beer/red wine/yellow wine/other

How much alcohol per week: ml

Duration of quitting: years

**Comorbidities**

1. COPD: yes/no, if yes

Duration since diagnose: years

Previous lung function tests reports:

Grades of mMRC:

Times of exacerbation last year: times

Times of hospitalization due to exacerbation last year: times

Medication:

1. asthma: yes/no, if yes

Duration since diagnose: years

Clinical status(4 weeks):

Seizure frequency during day time: times/week

Limitation of motion: yes/no

Arouse due to seizure at night: yes/no

Emergency medication or first aid: times/week

Lung function tests report:

Medication:

1. Medication history:

Antibiotics: yes/no, if yes, list reasons

Cortisone: yes/no, if yes, list reasons

Immunesupressor: yes/no, if yes, list reasons

1. Diabetes: yes/no, if yes

Duration since diagnose: years

Type: type 1/type 2/gestational diabetes/other type

Chronic complication: Diabetic Nephropathy/ retinopathy/ neuropathy/ macroangiopathy

Blood sugar control strategy: diet and exercise/biguanides/sulfonylureas/glinides/GSDI/TZD/DPP4 inhibitor/SGLT2 inhibitor/GLP-RA/insulin

Blood sugar level(fasting): 5-7mmol/L、7-10mmol/L、＞10mmol/L

1. Hypertension: yes/no, if yes

Duration since diagnose: years

Medication: CCB/ACEI/ARB/diuretic/compound preparation

1. Coronary heart disease: yes/no, if yes

Duration since diagnose: years

Myocardial infarction: yes/no

Coronary angiogram: yes/no

Stent implantation: yes/no

Coronary artery bypass surgery: yes/no

Medication: antiplatelet/statin/βblocker

Other heart diseases:

1. Sleep disorder: yes/no, if yes

Difficult in falling asleep: yes/no, if yes, time to fall asleep

Arouse at night: times

Early awakening: yes/no

Sleep duration per night: hours

Medication:

**Post-discharge condition**

1. Chronic cough after discharge: yes/no, if yes

Cough type: dry cough/sputum(color)

1. Dyspnea after discharge: yes/no, if yes, mMRC grades
2. The nucleic acid test: positive/negative, if positive, date of the positive test
3. IgM test: positive/negative
4. IgG test: positive/negative
5. Lung function test: yes/no, if yes, collect reports
6. Imageological examination: yes/no, if yes, collect reports

Sleep disorder after discharge

Difficult in falling asleep: (no/mild/moderate/severe)

Arouse at night: (no/mild/moderate/severe)

Early awakening: (no/mild/moderate/severe)

Sleep duration per night: hours

Do you feel satisfied with sleep status in the past month: (very satisfied/satisfied/dissatisfied/very dissatisfied)

How much do you think your sleep disorder interfere with your day(Such as daytime fatigue, ability to cope with daily tasks, concentration, memory, and mood): (no effect at all/ Occasional affected / Slightly affected/ affected/ definitely affected)

To what extent do you think sleep disorder affects your quality of life? (no effect at all/ Occasional affected /Slightly affected/ affected/ definitely affected)

Do you feel anxious about sleep disorder: (not at all/ slightly/ anxious/ definite anxious)

Sleep duration per night: hours

Medication:

**Psychological status after discharge:**

1. Have you lost a spouse and/or a third-generation relative (grandparent, maternal grandparent, parent, sibling, child) to coVID-19? (Yes/no)
2. Your overall satisfaction with your current life situation. (1= not at all satisfied; 4 = in general; =7 very satisfied)
3. I feel like someone discriminated against me because I had COVID-19. (1= disagree completely; 4= uncertainty; =7 Totally agree)
4. After discharge from hospital, have you visited the hospital for mental health problems (1- Yes; 2 - no)
5. Have you had the following symptoms in the last month?
6. Recurring thoughts of coVID-19 experiences or recurring nightmares (0- never; 1 - once in a while; 2 - sometimes; 3 - often; 4 - always)
7. Continually avoid memories or people, places, activities and situations associated with COVID-19 (0- never; 1 - once in a while; 2 - sometimes; 3 - often; 4 - always)
8. Thoughts related to coVID-19 events (e.g., the world is dangerous, I am bad or others are bad) and emotions (fear, fear, anger, guilt, inability to experience positive emotions) are negatively affected (0- never; 1 - once in a while; 2 - sometimes; 3 - often; 4 - always)
9. Responses associated with coVID-19 were significantly increased, such as irritability, recklessness, hypervigilance, attention problems, and sleep disorders (0- never; 1 - once in a while; 2 - sometimes; 3 - often; 4 - always)

Narrator: The patient himself/his family

Reliability: reliable/unreliable

Recorder: