

Form: Health Contact

Was the health contact completed? Yes

If "No", end of form. No

Contact date _____

What is the participant's vital status? Alive

If "Deceased", complete Study Termination CRF and end of form. Deceased

What is the participant's current independence with activities of daily living? Requires no assistance

Some assistance needed

Complete assistance needed

Does the participant require supplemental oxygen? Yes

No

Does the participant require dialysis? Yes

No

Since the study began, did the participant ever develop blood clots? Yes

No

Does the participant consider themselves to be recovered? Yes

No

If "Yes", end of form.

Symptom Assessment

Mark all ongoing symptoms.

Fever

Fatigue/Malaise

Myalgia

Chills

Headache

Nausea/Vomiting

Diarrhea/Abdominal pain

Cough

Chest congestion/Shortness of breath

Pharyngitis/Rhinorrhea

Anosmia/Ageusia

Other

If "Other", specify up to 3 symptoms below.

Specify (max 200 characters): _____

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Specify (max 200 characters): _____