1) Welcome and Consent

I consent to participate.

◯ [1]Yes
◯ [0]No

Question Type: Choose only 1
Branching logic: if [0]=checked, then go to Section 4) End of test

2) About your illness

In which year (YYYY) were you born?

Question Type: Numeric
Branching logic: if year of birth greater than 2001 then go to Section 4) End of test

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What is your current country of residence?

Question Type: Comment _____

Optional: What city, town, or region do you currently live in?

Question Type: Comment _____

Which gender do you most identify with?

◯ [0]Female
◯ [1]Male
◯ [2]Another not listed here
◯ [3]Prefer not to say

Question Type: Choose only 1

Within the past two weeks, have you been diagnosed with or suspect that you have a respiratory illness?

◯ [1]Yes
◯ [0]No

Question Type: Choose only 1
Branching: if [0]=checked, then go to Section 4) Re-contact

What **date** did you **first notice symptoms** of your recent respiratory illness? Provide your best guess or leave blank if you do not remember. Click the box below to display a calendar.

Question Type: Numeric

Have you been diagnosed with **COVID-19**?

◯ [1]Yes-diagnosed based on symptoms only
◯ [2]Yes-diagnosed with viral swab
◯ [3]Yes-diagnosed with another lab test
◯ [4]No-I was not diagnosed, but I have symptoms
◯ [5]No-I had a negative test, but I have symptoms
◯ [6]No-I do not have any symptoms
◯ [7]Don't Know
◯ [8]Other

Question Type: Choose only 1

Were you diagnosed with any **other** respiratory illnesses (**not COVID-19**) in the **last two weeks**? (Select all that apply)

☐ [1]Strep throat (Streptococcal bacteria)
☐ [2]Another bacterial illness
☐ [3]Flu (influenza)
☐ [4]Another viral illness
☐ [5]Other
☐ [6]None

Question Type: Choose n

Have you had any of the following symptoms with **your recent respiratory illness or diagnosis**? (Select all that apply)

- ☐ [1]Fever
- ☐ [2]Dry cough
- ☐ [3]Cough with mucus
- ☐ [4]Difficulty breathing/shortness of breath
- ☐ [5]Chest tightness
- ☐ [6]Runny nose
- ☐ [7]Sore throat
- ☐ [8]Changes in food flavor
- ☐ [9]Changes in smell
- ☐ [10]Loss of appetite
- ☐ [11]Headache
- ☐ [12]Muscle aches
- ☐ [13]Fatigue
- ☐ [14]Diarrhea
- ☐ [15]Abdominal pain
- ☐ [16]Nausea
- ☐ [17]No symptoms

Question Type: Choose n

Optional: Please describe the progression or order you noticed your symptoms

_____

Question Type: Comment

Optional: What treatment(s) or medication(s) have you received for your recent **respiratory illness or diagnosis**?

_____

Question Type: Comment

The next section of this survey is focused on your experience of smell, taste, and food flavor during your recent respiratory illness or diagnosis.

These questions relate to your <u>sense of smell</u> (for example, sniffing flowers or soap, or smelling garbage) but <u>not the flavor of food</u> in your mouth.

Rate your ability to **<u>smell</u>** BEFORE your **recent respiratory illness or diagnosis**

No sense of smell — Excellent sense of smell

(Place a mark on the scale above)

Question Type: Line Scale

Rate your ability to **<u>smell</u>** DURING your **recent respiratory illness or diagnosis**

No sense of smell — Excellent sense of smell

(Place a mark on the scale above)

Question Type: Line Scale

Have you experienced any of the following changes in **<u>smell</u>** with your **recent respiratory illness or diagnosis**? (Select all that apply)

- ☐ [1]I cannot smell at all / Smells smell less strong than they did before
- ☐ [2]Smells smell different than they did before (the quality of smell has changed)
- ☐ [3]I can smell things that aren't there (e.g, I smell burning when nothing is on fire)
- ☐ [4]Sense of smell fluctuates (e.g. comes and goes)

Question Type: Choose n

Optional: Please describe any changes in smell

_____

Question Type: Comment

How **blocked** was your nose BEFORE your **recent respiratory illness or diagnosis**?

Not at all blocked — Completely blocked

(Place a mark on the scale above)

Question Type: Line Scale

How **blocked** was your nose DURING your **recent respiratory illness or diagnosis**?

Not at all blocked — Completely blocked

(Place a mark on the scale above)

Question Type: Line Scale

The following questions are related to your sense of taste. For example sweetness, sourness, saltiness, bitterness experienced in the mouth

Rate your ability to **taste** BEFORE your **recent respiratory illness or diagnosis**

No sense of taste — Excellent sense of taste

(Place a mark on the scale above)

Question Type: Line Scale

Rate your ability to **taste** DURING your **recent respiratory illness or diagnosis**

No sense of taste — Excellent sense of taste

(Place a mark on the scale above)

Question Type: Line Scale

OPTIONAL: Have you experienced changes to **specific tastes** with your **recent respiratory illness or diagnosis**? (Select all that apply)

- ☐ [1]Sweet
- ☐ [2]Salty
- ☐ [3]Sour
- ☐ [4]Bitter
- ☐ [5]Savory/Umami

Question Type: Choose n

Optional: Describe any **changes in taste** during your **recent respiratory illness or diagnosis**.

Question Type: Comment

The following questions are related to other sensations in your mouth, like burning, cooling, or tingling. For example chili peppers, mint gum or candy, or carbonation.

Rate your **ability to feel these other sensations** BEFORE your **recent respiratory illness or diagnosis**.

Not sensitive at all — Very sensitive

(Place a mark on the scale above)

Question Type: Line Scale

Rate your **ability to feel these other sensations** DURING your **recent respiratory illness or diagnosis**

Not sensitive at all — Very sensitive

(Place a mark on the scale above)

Question Type: Line Scale

Optional: Describe any **changes in these other sensations** during your **recent respiratory illness or diagnosis**.

Question Type: Comment

Optional: Think about a food or beverage you consume regularly - for example, your morning coffee or tea or a piece of fruit you have each day. Has the taste, smell, or flavor changed with your recent respiratory illness or diagnosis? If so, **please describe how and be sure to indicate which food or beverage you are describing**.

Question Type: Comment

Optional: Is there anything else you would like to tell us about how your recent respiratory illness or diagnosis has affected your sense of smell, taste, and flavor?

Question Type: Comment

Have you recovered from your **recent respiratory illness or diagnosis**? (For example you no longer have a cough, fever, or shortness of breath.)

- ◯ No
- ◯ Yes - partly
- ◯ Yes - fully
- ◯ Don't know

Question Type: Choose only 1
Branching: if [0]=checked, then go to Section 3) General Health Information

The next section of this survey is focused on your experiences of smell, taste, and food flavor after your recovery from your recent respiratory illness or diagnosis.

Rate your ability to **smell** AFTER your recovery

No sense of smell — Excellent sense of smell

(Place a mark on the scale above)

Question Type: Line Scale

How **blocked** was your nose AFTER your recovery

Not at all blocked — Completely blocked

(Place a mark on the scale above)

Question Type: Line Scale

Rate your ability to **taste** AFTER your recovery

No sense of taste — Excellent sense of taste

(Place a mark on the scale above)

Question Type: Line Scale

Rate your **ability to feel these other sensations like burning, cooling, and tingling** AFTER your recovery

Not sensitive at all — Very sensitive

(Place a mark on the scale above)

Question Type: Line Scale

How were you directed to this survey?

- ☐ [1]Clinician or healthcare professional
- ☐ [2]Media (social media, print, radio, tv, etc)
- ☐ [3]Word of mouth
- ☐ [4]Other

Question Type: Choose only 1

The next section of this survey will ask some optional questions about your habits and general health.

. General Health Information

Optional: Have you smoked at least 100 combustible cigarettes or cigars in your entire life?

- ◯ [0]No
- ◯ [1]Yes
- ◯ [2]Prefer not to say
- ◯ [3]Don't know

Question Type: Choose only 1

Optional: During the past 30 days, on how many days did you smoke combustible cigarettes or cigars?

_____

Question Type: Numeric

Optional: Have you ever used an e-cigarette ('vaped'/'Juuled') even one time? (E-cigarettes are battery-powered devices that usually contain liquid nicotine, and do not produce smoke.)

- ◯ [0]No
- ◯ [1]Yes
- ◯ [2]Prefer not to say
- ◯ [3]Don't know

Question Type: Choose only 1

Optional: During the past 30 days, on how many days did you use an e-cigarette?

_____

Question Type: Numeric (range 0-30; integer)

Did you have any of the following **in the 6 months prior** to your recent respiratory illness or diagnosis? (Select all that apply)

- ☐ [1]High blood pressure
- ☐ [2]Heart disease (heart attack or stroke)
- ☐ [3]Diabetes (high blood sugar)
- ☐ [4]Obesity
- ☐ [5]Lung disease (asthma/COPD)
- ☐ [6]Head trauma
- ☐ [7]Neurological disease
- ☐ [8]Cancer that required chemotherapy or radiation
- ☐ [9]Cancer that did NOT require chemotherapy or radiation
- ☐ [10]Chronic sinus problems
- ☐ [11]Seasonal allergies/hay fever
- ☐ [12]None

Question Type: Choose n

Optional: Any other medical conditions that you would like to mention?

_____

Question Type: Comment

Optional: Which medication(s) do you take regularly? For example, medications for pain, blood pressure, thyroid function, anti-viral, etc.

_____

Question Type: Comment

Optional: Is there anything we didn't ask about that you would like to share with us?

Question Type: Comment

. Re-contact

We may want to re-contact you for follow up research on this topic. **Is it okay if our team or other researchers re-contact you to participate in future research**? By saying yes, you agree that we can share your email address with other researchers for this purpose.

◯ [1]Yes
◯ [0]No

Question Type: Choose only 1

Branching logic: if [0]=checked, then go to: Section 5)End of test

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Please provide your full email address, so you can be contacted for future studies by our team or other researchers.

Question Type: Comment

. End of Test

You have now completed the survey and may close your browser

Thank you for your time!

Notes

"In which year (YYYY) were you born?
-- value must be 1900 or greater
What **date** did you **first notice symptoms** of your recent respiratory illness? Provide your best guess or leave blank if you do not remember. Click the box below to display a calendar"
-- format (mm/dd/yyyy)
"Have you been diagnosed with COVID-19"
-- if [8] Other was selected, a comment is required
"Were you diagnosed with any other respiratory illnesses (not COVID-19) in the last two weeks? (Select all that apply)"
-- if [6] None was selected, no other options can be selected.
"Have you had any of the following symptoms with your **recent respiratory illness or diagnosis**? (Select all that apply)"
-- if [17] No symptoms was selected, no other options can be selected.
"Rate your ability to smell BEFORE your **recent respiratory illness or diagnosis**"
-- Line Scale Range 0-100, intervals of 1. All following line scales formatted similarly
'**OPTIONAL**: During the past 30 days, on how many days did you smoke combustible cigarettes or cigars?" and "**OPTIONAL**: During the past 30 days, on how many days did you use an e-cigarette?"
-- value must be between 0-30
Did you have any of the following in the 6 months prior to your **recent respiratory illness or diagnosis**? (Select all that apply)
-- if [12] None was selected, no other options can be selected.