

environmental, etc)

Skin rashes

Other _____

All Other Symptoms - Checkbox

2. Have you experienced any of these symptoms since the start of your COVID-19 illness? (Please choose all options that apply)

Skin and Allergy

New allergies (food, chemical, environmental, etc)

Heightened reaction to old allergies

Itchy skin

Itchy eyes

Itchy other _____

Brittle/discolored nail

Shingles

None of the above

Symptom Course

3. How severe were/are your symptoms over the course of the weeks/months?

If you experienced multiple severities for symptoms within the time period, select the most severe within that time period.

No symptom Very Mild Mild Moderate Severe Very Severe

Week 1

Week 2

Week 3

Week 4

Month 2

Month 3

Month 4

Month 5

Month 6

Month 7+

4. Which of these descriptions appropriately describes your experience with relapses, and your symptom course overall? Please select all that apply:

- My relapses happen in a regular pattern (monthly, daily, or weekly).
- My relapses happen in an irregular pattern (randomly).
- My relapses happen in response to a trigger (stress, alcohol, exercise/exertion, etc).
- My relapses are getting shorter/easier over time.
- My relapses are getting longer/harder over time.
- My relapse severity has stayed about the same over time.
- Overall, my symptoms have slowly gotten better over time.
- Overall, my symptoms have stayed about the same over time.
- Overall, my symptoms have slowly worsened over time.
- I got worse rapidly.
- I got better rapidly.
- Other _____

7. Which of these trigger a relapse or worsening of symptoms? Please select all that apply:

- Stress

- Alcohol
- Caffeine
- Heat
- Period/menstruation
- Week before period/menstruation
- Exercise
- Physical activity
- Mental activity
- Other _____

Protocol source: <https://www.phenxtoolkit.org/protocols/view/992013>