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Questions

COVID 19 Questionnaire

Form description

1. Do you agree to participate in this questionnaire?

Yes

No

2. Name

Short-answer text

3. Age

Short-answer text

4. Gender

Male

Female

5. Smoking

No

Yes (≤ 20 cigarette /day)

Yes (≥ 20 cigarette /day)

6. Do you have any medical condition?

Hypertension

Diabetes Mellitus

Cardiovascular disease

Thyroid disease

Asthma

No

7. Are you on any long-term medications? if yes state the name of the medication

Antihypertensive drugs

Thyroid drugs

Antidiabetic drugs

Corticosteroids

Aspirin

Hormones
Vitamins
Others
No

8. How would you describe the severity of your past/present confirmed COVID19 illness?
Mild
Moderate
Severe
Critical

9. If recovered, how long have passed since your recovery?
1 month
3 months
6 months
1 year
2 years
3 years

10. Did you have any symptom of a dry mouth during your illness?
(You can select more than one answer)
Your mouth feels dry.
Your lips feel dry.
Difficulty in eating dry foods.
Difficulty in swallowing
Difficulty in speaking
Sip liquids to aid in swallowing.
Sip liquids to aid in speaking.
Get up at night to drink.
Nothing

11. Intensity of dry mouth symptoms
absent
1
2

3
4
5
6
7
8
9
10
severe

12. Duration of dry mouth symptoms

1 months
2 months
3 months
1 year
2 years
3 years

13. How severely is your quality of life affected by having a dry mouth?

No effect on quality of life
1
2
3
4
5
6
7
8
9
10
Worst possible effect on quality of life

14. Did you have any symptom of taste disturbance during your illness?

(You can select more than one answer)
Reduced ability to taste sweet food.
Reduced ability to taste sour food.
Reduced ability to taste bitter food.

Reduced ability to taste salty food.
Inability to correctly identify some tastes.
Metallic, bitter, or salty taste in the absence of a stimulus
Presence of a foul or unpleasant taste
Complete taste loss
Nothing

15. Intensity of the taste disturbance symptom
absent
1
2
3
4
5
6
7
8
9
10
Severe

16. Duration of the taste disturbance symptom
1 months
2 months
3 months
1 year
2 years
3 years

17. How severely is your quality of life affected by your taste disturbance?
No effect on quality of life
1
2
3
4
5

6
7
8
9
10
Worst possible effect on quality of life

18. Did you have any smell disturbance symptoms during your illness?
(You can select more than one answer)
Partial loss of smell sensation
Complete loss of smell sensation
Inability to correctly identify some smells.
Sensation of a smell that isn’t there.
Nothing

19. Intensity of the smell disturbance symptom
absent
1
2
3
4
5
6
7
8
9
10
Severe

20. Duration of the smell disturbance symptom
1 months
2 months
3 months
1 year
2 years

21. How severely is your quality of life affected by this smell disturbance?

No effect on quality of life

1

2

3

4

5

6

7

8

9

10

Worst possible effect on quality of life

22. Do you feel any pain or burning sensation in your mouth without apparent cause?

Yes

No

23. How severely is your quality of life affected by this burning sensation?

No effect on quality of life

1

2

3

4

5

6

7

8

9

10

Worst possible effect on quality of life