**COVID-19 Infection Symptoms Questionnaire（First Test）**

Name:\_\_\_\_\_ Team:\_\_\_\_\_

* Date of first negative results in nucleic acid/antigen test: \_\_\_\_\_\_\_\_\_\_
* Date of first negative results in nucleic acid/antigen test after infection: \_\_\_\_\_\_\_\_\_\_
* Date of return training: \_\_\_\_\_\_\_\_\_\_
* Did you have fever during the infection? Yes No
* If you chose "Yes" in the last question, please fill in the maximum temperature of fever: \_\_\_\_\_\_\_\_\_\_
* Did you have any of the following symptoms during the infection? (√)

|  |  |
| --- | --- |
| Dry cough |  |
| Fatigue |  |
| Sore throat |  |
| Decreased smell/taste |  |
| Diarrhea |  |
| Muscle aches |  |
| Sleepiness |  |

* Do you still have any of the following symptoms as of now? (√)

|  |  |
| --- | --- |
| Dry cough |  |
| Fatigue |  |
| Sore throat |  |
| Decreased smell/taste |  |
| Diarrhea |  |
| Muscle aches |  |
| Sleepiness |  |

* Compared to when you get your first negative result after infection, you feel that you are now:

( ) very much worse

( ) worse

( ) a little worse

( ) no change

( ) a little improved

( ) improved

( ) very much improved

**COVID-19 Infection Symptoms Questionnaire（Second/Third Test）**

Name:\_\_\_\_\_ Team:\_\_\_\_\_

* Do you still have any of the following symptoms as of now? (√)

|  |  |
| --- | --- |
| Dry cough |  |
| Fatigue |  |
| Sore throat |  |
| Decreased smell/taste |  |
| Diarrhea |  |
| Muscle aches |  |
| Sleepiness |  |

* Compared to the previous test, you feel that you are now:

( ) very much worse

( ) worse

( ) a little worse

( ) no change

( ) a little improved

( ) improved

( ) very much improved