Questionnaire

Name

Date

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| --- | --- | --- |
| Fatigue | Yes | No |
| Breathlessness | Yes | No |
| Cough/sputum | Yes | No |
| Decline in cognitive dysfunction/concentration | Yes | No |
| Headache | Yes | No |
| Diarrhea | Yes | No |
| Taste disorder | Yes | No |
| Olfactory disorder | Yes | No |
| Hair loss | Yes | No |
| Depression | Yes | No |