Stanford
HEALTH CARE
STANFORD MEDICINE

First assessment Post Covid infection

Name: ___________________________________ Date of Birth: _________

COVID-19 Symptoms: Start date ____________ Duration of Symptoms (days)__________

Date of Positive Test *(if not done at Stanford, please provide copy of the results)*: ____________

What were your symptoms during the initial COVID-19 infection? Please also select severity.

Symptoms during acute COVID-19 Infection	Yes	No	**Severity (1=mild, 5=severe)**
Fever			
Chills			
Headache			
Decrease appetite			
Nose congestion			
Sore throat			
Fatigue			
Brain fog or confusion			
Unrefreshing sleep			
Difficulty sleeping			
Daytime sleepiness			
More fatigue with activity			
Change in smell			
Change in taste			
Ear pain			
New anxiety or depression			
Paranoid thoughts			
Hallucinations			
Cough			
Chest pain			
Difficulty breathing at rest			
Difficulty breathing while walking			
Wheezing			

Lightheadedness on standing			
Fainting spells			
Changes in sweating (more or less)			
Nausea, vomiting, or diarrhea, bloating or constipation			
Changes in color of hands or feet			
Urinary difficulties			

What was your functional status during your initial acute COVID-19 infection?

COVID-19 Infection Functional Status	Yes	No	Stage
No symptoms			I
No limitation but I felt the COVID-19 symptoms			II
I avoided some of my daily activities			III
I struggled to take care of myself			IV
I was in bed all the time			V
I was hospitalized for my COVID-19 infection			Severe

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Completion of this pre-assessment form is required before scheduling, thank you.

*modified scale from reference: Klok FA, Boon GJAM, Barco S, et al. The Post-COVID-19 Functional Status scale: a tool to measure functional status over time after COVID-19. Eur Respir J 2020; 56: 2001494