**Supporting Information: Part 1: Participant demographics questions**

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| --- | --- | --- |
|  | Question | Answer field |
| 1 | **Date of birth** | DD/MM/YYYY |
| 2 | **Sex** | FemaleMale Other |
| 3 | **Ethnicity** | WhiteBlackAsianMixedOtherI do not wish to disclose |
| 4 | **Have you ever smoked?** | Current smokerEx-smokerNever smoked |

**Supporting Information: Part 2: Participant baseline symptom questionnaire**

|  |  |  |
| --- | --- | --- |
|  | Question | Answer field |
| 1 | **Have you noticed any changes in your sense of smell?** | YesNo |
| 1.2 | **How would you describe the change in your sense of smell?** | * I can/could no longer smell any odours that I used to be able to smell
* I can/could no longer smell some odours I used to be able to smell Describe (optional)
 |
| 1.3 | **Have you noticed that odours smell different than they used to?** | No Yes If yes describe (optional) |
| 2 | **Have you noticed any changes in your sense of taste?** | YesNo |
| 2.1 | **How would you describe the changes in your sense of taste?** | * I can/could no longer taste any foods or drinks
* My ability to taste food or drinks is/was reducedDescribe (optional)
 |
| 2.2 | **Have you noticed that foods and drinks taste differently?** | YesNoIf yes describe (optional) |
| 2.3 | **Have you experienced any unusual tastes while not eating or drinking?** | YesNoIf yes describe |
| 3 | **Have you experienced any of these symptoms in the last 4 weeks?** | Cough  | Yes/No |
| Fever (37.8◦C or more) |  |
| Shortness of breath |  |
| Headache |  |
| Sore throat |  |
| Hoarse voice |  |
| Chest pain/tightness |  |
| Abdominal pain |  |
| Diarrhoea |  |
| Vomiting |  |
| Confusion, disorientation or drowsiness |  |
| Muscle/joint aches |  |
| 4 | **Has/was your appetite for food decreased?** | YesNo |
| 5 | **Have you had a test for COVID-19?** | YesNoIf Yes: positive negativeType of test: swab test blood testLocation of test |

**Supporting Information: Part 3: Participant follow-up symptom questionnaire**

|  |  |  |
| --- | --- | --- |
|  | Question | Answer field |
|  | Participant number |  |
| 1 | **Did the changes in your sense of smell resolve?** | Resolved fully Date:Resolved partiallyDid not resolve |
| 2 | **Did the changes in your sense of taste resolve?** | Resolved fully Date:Resolved partiallyDid not resolve |
| 3 | **Did your other symptoms resolve?**If yes please enter the date these resolved | Cough  | Resolved?Yes/No |
| Fever (37.8◦C or more) |  |
| Shortness of breath |  |
| Chest pain/tightness |  |
| Headache |  |
| Sore throat |  |
| Hoarse voice |  |
| Abdominal pain |  |
| Diarrhoea |  |
| Vomiting |  |
| Confusion, disorientation or drowsiness |  |
| Muscle/joint aches |  |
| 4 | **Have you developed any of the following symptoms in the last 4 weeks?** | Cough | Yes/No |
| Fever (37.8◦C or more) |  |
| Shortness of breath |  |
| Chest pain/tightness |  |
| Headache |  |
| Sore throat |  |
| Hoarse voice |  |
| Abdominal pain |  |
| Diarrhoea |  |
| Vomiting |  |
| Confusion, disorientation or drowsiness |  |
| Muscle/joint aches |  |
| 5 | **Have you attended/been admitted to hospital due to COVID-19?** | YesNo |