Post-COVID health history and symptom checklist

CardioSmart
AMERICAN COLLEGE of CARDIOLOGY

COVID-19 | Worksheet

Having had COVID-19 is an important part of your health history – now and in the future. **Use this worksheet to write down the details of your COVID illness, as well as any new or lingering symptoms that might need to be checked.**

This information also will help you and your care team understand how your health may have changed after COVID.

Before having COVID

Did you already have heart disease or risk factors, such as high blood pressure or high cholesterol, or is this new for you?

- ☐ Yes, I had heart issues
- ☐ No, I didn't have any heart issues or wasn't aware of any

If yes, please explain:

_____

_____

Your Health

If you have heart disease or other health conditions, it can be hard to know what symptoms or health changes are due to COVID versus other illnesses.

Share your questions with your care team. They can help sort through your symptoms and why you might be having them.

About your COVID illness

When did you last have COVID? _____ /_____ /_____

Was this the first time you had COVID or knew you had it?

☐ Yes ☐ No If no, list other infections and when, if known: _____

_____

_____

Your vaccine history

- ☐ I'm not vaccinated
- ☐ First vaccine(s) (Circle which one: Moderna, Pfizer, Johnson & Johnson)
- ☐ First vaccine(s) plus a booster
- ☐ First vaccine(s) plus two boosters

If known, what was the date of your most recent COVID vaccine/booster: ____ /____ /____

Was your COVID illness:

- ❑ Asymptomatic (I had no symptoms)
- ❑ Mild (some symptoms like headache, cough, fever, body aches, but no shortness of breath)
- ❑ Moderate (affected the lungs, perhaps resulting in pneumonia or bronchitis; the amount of oxygen in the blood was lower than normal)
- ❑ Severe (required hospitalization, the number of breaths you took per minute was higher than normal and/or the amount of oxygen in the blood was much lower than normal)
- ❑ Critical (required care in the intensive care unit, or ICU)

Would you say that having COVID was:

- ❑ Like a mild cold
- ❑ Similar to the worst cold or flu that you've ever had
- ❑ Somewhere in between
- ❑ None of above – you wouldn't have known you had it but for a positive COVID test

What were your main symptoms? (Check all that apply)

- ❑ Cough
- ❑ Fever or chills
- ❑ Headache
- ❑ Sore throat
- ❑ Congestion or runny nose
- ❑ Shortness of breath or difficulty breathing
- ❑ Fatigue
- ❑ Muscle pain or body aches
- ❑ New loss of taste or smell
- ❑ Nausea
- ❑ Vomiting or diarrhea
- ❑ Other: _____

Did you:

❑ Recover at home ❑ Go to the hospital

If you were in the hospital:
How many days did you stay?_____

Did you need to be treated in the ICU?

❑ Yes ❑ No

What was the main health issue they treated you for in the hospital?

_____

Were you given any of the following to help treat the infection? (Check all that apply)

- ❑ Antibody therapy
- ❑ Steroids
- ❑ Remdesivir
- ❑ IL-6 inhibitor (for example, tocilizumab)
- ❑ Antiviral pills (nirmaltrelvir/ritonavir, also known as Paxlovid, or molnupiravir)
- ❑ Other: _____

Symptoms after COVID

Tell us a little about any symptoms you've had since your COVID illness.

Since having COVID, have you had any lingering or new symptoms?

❑ Yes ❑ No

If yes, which ones? For example:

Symptom	When did it start?	How often (daily, every few days, once in a while)?	What, if anything, seems to make it worse?
❑ Chest pain			
❑ Shortness of breath			
❑ Palpitations, like your heart skips a beat			
❑ Fast beating or pounding heart (tachycardia)			
❑ Not being able to exercise or worsening of symptoms after exerting yourself			
❑ Feeling unusually tired			
❑ Difficulty concentrating or thinking ("brain fog")			
❑ Feeling weak, lightheaded			
❑ Joint or muscle pain			
❑ Depression or anxiety			
❑ Trouble sleeping			
❑ Others:			

Which symptoms are most bothersome or worrisome to you? Please explain.

_____

_____

How long have you had these symptoms?

- ☐ A few weeks
- ☐ A month
- ☐ 2-3 months
- ☐ Over 3 months

Do these symptoms make it hard for you to: (Check all that apply)

- ☐ Work
- ☐ Take care of others
- ☐ Do daily activities (for example, bathing, grooming, eating)
- ☐ Be active, exercise
- ☐ Be social
- ☐ Enjoy my relationships
- ☐ Have a good quality of life in general
- ☐ Other: _____

Compared with before you got COVID, would you say that your current health is:

- ☐ Better
- ☐ Worse
- ☐ The same
- ☐ Other: _____

Have you been monitoring any of these at home?

- ☐ Heart rate
- ☐ Oxygen saturation
- ☐ Heart rhythm
- ☐ Your symptoms – when they get worse or better
- ☐ Other: _____

Have you seen any other doctors to help manage post-COVID health concerns? If yes, please provide name and specialty and any tests that were done.

Clincian name and phone number	Tests or imaging ordered

Anything else that you would like to discuss?

_____

_____

_____

_____