1. **Date of completion of the questionnaire:**
2. **Do you agree to participate in the anonymous poll (required):**
* Yes
* No
1. **Your gender (required):**
* Male
* Female
* Other
1. **Your age (mandatory):**
2. **Your education (required):**
* Primary / secondary;
* Higher / higher non-university
* Higher university
1. **You are (required):**
* Employed
* Unemployed
* Retired
* Temporarily incapacitated
1. **In which county of Lithuania do you live (required):**
* Vilnius county
* Kaunas county
* Klaipėda county
* Alytus county
* Šiauliai county
* Panevėžys county
* Marijampolė county
* Tauragė county
* Telšiai county
* Utena county
1. **Your place of residence (optional):**
* City
* District
* Settlement
* The village
1. **Do you have a chronic illness (required):**
* Yes
* No
1. **If you answered "yes" to the previous question, please indicate which chronic diseases you have (several suitable options are available). If no, please tick "I'm not sick: (required)**
* Asthma
* Hypothyroidism
* Diabetes mellitus
* High blood pressure (Arterial hypertension)
* Obesity
* Chronic pain syndrome
* Anxiety
* Depression
* Blood clotting disorders
* Rheumatic diseases
* Neurological diseases
* Diseases of the gastrointestinal tract
* Allergic diseases
* Other metabolic diseases
* Other lung diseases
* Other cardiovascular diseases
* Psychiatric illnesses
* Oncological diseases
* Kidney disease
* Immunodeficiency diseases / conditions
* Sleep disorders
* I'm not sick
1. **Please indicate your other specific conditions (which were not listed in the previous questions) (optional):**
* ...
1. **Did you take any medication every day before you became ill with Covid-19 due to your medical condition? (required)**
* Yes
* No
1. **If you answered "YES" to the previous question, list the medications you were taking (optional):**

**...**

1. **How would you describe your physical activity prior to COVID-19? (required)**
* Professional athlete
* Amateur athlete
* Daily physical activity for your enjoyment
* To the extent required by daily activities and / or work
* Almost physically inactive
1. **How would you describe your health (health condition) before you became ill with COVID-19? (required)**
* Great
* Very good
* Good
* Not bad
* Bad
1. **Have you experienced at least one symptom of COVID-19? (required)**
* Yes
* No
1. **When did the first symptoms of COVID-19 occur (if the disease was symptomatic) (optional):**
* (enter the date)
1. **Have you had a test for COVID-19? (required)**
* Yes
* No
1. **If the test was performed, indicate when: (optional)**
* (enter the date)
1. **Where have you been treated for COVID-19: (required)**
* At home
* In the hospital
* Other
1. **Have you been treated with medication: (required)**
* No, no treatment was needed
* Yes, I was treating myself
* Yes, the treatment was prescribed by a doctor
1. **If you have been treated with medication during acute COVID-19 infection, please list the following (optional):**
* ...
1. **In how many days did you officially recover from an acute infection (your GP / other specialist has confirmed that you have recovered from COVID-19) (required)?**
* For a period of up to 14 days
* Within 14 - 28 days
* In 28 days or more
* Other
1. **Did the symptoms of COVID-19 remain the same (from the beginning to the end of the disease) or did they change (some symptoms disappeared, others occurred) (required):**
* The symptoms remained the same
* The symptoms changed over the course of the disease
* Many have survived and developed new ones
* I had an asymptomatic form
1. **Mark the symptoms you have officially experienced with COVID-19: you can choose all the appropriate options: (required)**
* Fever / chills
* Chills without fever
* Body / muscle / bone / joint pain
* Shortness of breath / difficulty breathing
* Cough / sputum
* Dry cough
* Sore throat
* Mouth ulcers / ulcers
* Great / constant thirst
* Chest pain / pressure
* Headache / dizziness
* Partial / complete loss of smell
* Partial / complete loss of taste
* Clogged / running nose
* Lack of appetite
* Insomnia
* Severe / unusual drowsiness
* Other Sleep disorders
* Anxiety
* Fear
* Fatigue
* Loss of physical capacity / lack of strength
* Mood swings (sadness, confusion, irritability)
* Heart palpitations / tachycardia / arrhythmia
* High blood pressure
* Low blood pressure
* Prolonged fever
* Unusually low body temperature
* Nausea
* Vomiting
* Diarrhea / constipation
* Reflux / heartburn
* Renal pain / urinary disorders
* Night sweats
* Weight loss
* Weight gain
* Blurred vision
* Blinking / blinking in the eyes
* "Dry" eyes
* Inflammation of the eyes / barley
* Feet, numbness, swelling, pain in the feet
* Freezing / numbness / pain / swelling of the hands
* Other neuralgic pains
* Lower back pain
* Upper back / neck pain
* Hearing impairment (murmur / tinnitus)
* Cramps / twitching of various muscles in the body
* Dry, scaly skin
* Various skin rashes
* Hair loss
* Painful / sensitive scalp
* There were no symptoms
1. **Did the symptoms of COVID-19 disappear after the official recovery? (required)**
* Yes, I don’t feel any residual symptoms
* No, the symptoms persisted for some time and then disappeared
* No, the symptoms are not gone and some I feel so far
* I had an asymptomatic form
1. **If the symptoms have not disappeared, indicate what is officially left / tired AFTER COVID-19: you can choose all the appropriate options: (required)**
* I have no symptoms
* Fever / chills
* Chills without fever
* Body / muscle / bone / joint pain
* Various migratory / bothersome body aches where it is difficult to pinpoint one specific sore spot
* Shortness of breath / difficulty breathing
* Cough / sputum
* Dry cough
* Sore throat
* High salivation
* Dry throat / bump in the throat
* Mouth ulcers / ulcers
* Great / constant thirst
* Chest pain / pressure
* Headache / dizziness
* "Brain pressure", heavy head, occiput pain
* Partial / complete loss of smell
* Partial / complete loss of taste
* Clogged / running nose
* Lack of appetite
* Attention, concentration, concentration disorders
* Memory disorders
* Changing symptoms (some appear, some go away)
* Insomnia
* Severe / unusual drowsiness
* Other Sleep disorders
* Anxiety
* Fear
* Fatigue
* Loss of physical capacity / lack of strength
* Mood swings (sadness, confusion, irritability)
* Heart palpitations / tachycardia / arrhythmia
* High blood pressure
* Low blood pressure
* Prolonged fever
* Unusually low body temperature
* Nausea
* Vomiting
* Diarrhea / constipation
* Reflux / heartburn
* Renal pain / urinary disorders
* Night sweats
* Weight loss
* Weight gain
* Blurred vision
* Blinking / blinking in the eyes
* "Dry" eyes
* Inflammation of the eyes / barley
* Feet, numbness, swelling, pain in the feet
* Freezing / numbness / pain / swelling of the hands
* Other neuralgic pains
* Lower back pain
* Upper back / neck pain
* Hearing impairment (murmur / tinnitus)
* Cramps / twitching of various muscles in the body
* Dry, scaly skin
* Various skin rashes
* Hair loss
* Painful / sensitive scalp
* Inflammations / infections of other organs / systems of the body
* Anemia
1. **Are you temporarily incapacitated for work due to persistent symptoms (do you have a certificate of incapacity for work)? (required)**
* Yes
* No
* Other
1. **If you are temporarily unable to work, indicate how long (number of days)? (required)**
* (write in)
1. **Have you consulted a doctor about residual symptoms? (required)**
* Yes, I applied and received a consultation
* No, I didn't
* I applied but did not receive a consultation
1. **Did you apply for rehabilitation consultation / rehabilitation treatment: (required**
* Yes, I did. I received counseling and rehabilitation treatment
* Yes, I applied, but I was not referred for a rehabilitation consultation / rehabilitation treatment
* No, I didn't
1. **Do you think you would need / benefit from rehabilitation treatment? (required)**
* Yes
* No.
* I have no opinion
1. **Would you take advantage of free rehabilitation treatment? (required)**
* Yes
* No.
* I have no opinion
1. **Do you intend to use / have you already used paid rehabilitation programs for the treatment of “post-epidemic” syndrome? (required)**
* I'm going to take advantage
* I am not going to because I do not have the funds to do so
* I’m not going to because I don’t see a need
* I was not aware of such a possibility
1. **How has your health changed since before COVID-19: (required)**
* I fully recovered after a COVID-19 crash
* Slightly worse than before COVID-19 disease
* Significantly worse than before COVID-19 disease
1. **Does your medical condition limit your active physical activity after COVID-19? (required)**
* Yes, very limiting
* Yes, a little limiting
* No, not at all restrictive
1. **Does your condition limit your daily activities after COVID-19? (required)**
* Yes, very limiting
* Yes, a little limiting
* No, not at all restrictive
1. **Does your medical condition limit your work / ability to work after COVID-19? (required)**
* Yes, very limiting
* Yes, a little limiting
* No, not at all restrictive
1. **Did you have to give up / stop / interrupt / change your active physical / daily / work activities after COVID-19? (required)**
* No, I work in a normal workload, do daily work, do normal physical activities
* I had to reduce my workload, but I do my daily work, I do my usual physical activities
* I had to reduce my physical activity and / or change my nature / intensity
* I am incapacitated and have a harder time and / or need help with my usual daily work
* After a case of COVID-19, I am still unable to work, do not engage in active physical activity, have daily work difficulties and / or need the help of another person
1. **Does your emotional / psychological condition (anxiety, fear, depression, fatigue, mood swings, etc.) limit your active physical / daily / work activities? (required)**
* Yes, very limiting
* Yes, a little limiting
* No, not at all restrictive
* No, I did not feel such symptoms
1. **Do you feel progression and / or improvement in residual symptoms? (required)**
* Symptoms change / progress, condition does not improve
* Symptoms worsen / improve, condition improves
* I have a hard time assessing my health
* I don’t feel any residual symptoms
1. **Have you been diagnosed with any new disease after COVID-19 that you did not have before COVID-19 infection? If YES, enter:**

**...**

1. **If you have COVID-19, are you taking any medicines every day that you did not take before the infection (new prescription / over-the-counter medicines, food supplements, etc.). If YES, please enter:**

**...**

1. **Please select the statement that best describes your health status in the near future: (required)**
* I think health will recover and I will be a healthy person
* I think the current symptoms will go away in part, but I will still be able to feel healthy
* I believe the current symptoms will persist and my health will deteriorate
* I have no opinion
* My health is the same as before COVID-19

**45. Are you vaccinated with COVID-19?**

* No
* Yes, I have been vaccinated with one dose of the vaccine
* I have thus been vaccinated with two doses of the vaccine
* I have thus been vaccinated with three doses of the vaccine
* I'm not going to get vaccinated
* Other

**46. If you have any additional comments / information that were not asked in the questionnaire, please write here (or you can contact us in person by e-mail: pokovidinissindromas@gmail.com):**

…

Thanks for the answers.