1) Welcome and Consent

I consent to participate.  

[ ] Yes  [ ] No

Question Type: Choose only 1  
Branching logic: if [0]=checked, then go to Section 4) End of test

2) About your illness

In which year (YYYY) were you born?

Question Type: Numeric  
Branching logic: if year of birth greater than 2001 then go to Section 4) End of test

What is your current country of residence?

Question Type: Comment

Optional: What city, town, or region do you currently live in?

Question Type: Comment

Which gender do you most identify with?

[ ] Female  [ ] Male  [ ] Another not listed here  [ ] Prefer not to say

Question Type: Choose only 1

Within the past two weeks, have you been diagnosed with or suspect that you have a respiratory illness?

[ ] Yes  [ ] No

Question Type: Choose only 1  
Branching: if [0]=checked, then go to Section 4) Re-contact

What date did you first notice symptoms of your recent respiratory illness? Provide your best guess or leave blank if you do not remember. Click the box below to display a calendar.

Question Type: Numeric

Have you been diagnosed with COVID-19?

[ ] Yes-diagnosed based on symptoms only  [ ] Yes-diagnosed with viral swab  [ ] Yes-diagnosed with another lab test  [ ] No-I was not diagnosed, but I have symptoms  [ ] No-I had a negative test, but I have symptoms  [ ] No-I do not have any symptoms  [ ] Don’t Know  [ ] Other

Question Type: Choose only 1

Were you diagnosed with any other respiratory illnesses (not COVID-19) in the last two weeks?  (Select all that apply)

[ ] Strep throat (Streptococcal bacteria)  [ ] Another bacterial illness  [ ] Flu (influenza)  [ ] Another viral illness  [ ] Other  [ ] None

Question Type: Choose n
Have you had any of the following symptoms with your recent respiratory illness or diagnosis? (Select all that apply)

- [ ] 1] Fever
- [ ] 2] Dry cough
- [ ] 3] Cough with mucus
- [ ] 4] Difficulty breathing/shortness of breath
- [ ] 5] Chest tightness
- [ ] 6] Runny nose
- [ ] 7] Sore throat
- [ ] 8] Changes in food flavor
- [ ] 9] Changes in smell
- [ ] 10] Loss of appetite
- [ ] 11] Headache
- [ ] 12] Muscle aches
- [ ] 13] Fatigue
- [ ] 14] Diarrhea
- [ ] 15] Abdominal pain
- [ ] 16] Nausea
- [ ] 17] No symptoms

Question Type: Choose n

Optional: Please describe the progression or order you noticed your symptoms

Question Type: Comment

Optional: What treatment(s) or medication(s) have you received for your recent respiratory illness or diagnosis?

Question Type: Comment

The next section of this survey is focused on your experience of smell, taste, and food flavor during your recent respiratory illness or diagnosis.

These questions relate to your sense of smell (for example, sniffing flowers or soap, or smelling garbage) but not the flavor of food in your mouth.

<table>
<thead>
<tr>
<th>Question</th>
<th>Type</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate your ability to smell BEFORE your recent respiratory illness or diagnosis</td>
<td>Line Scale</td>
<td>Excellent sense of smell</td>
</tr>
<tr>
<td>Rate your ability to smell DURING your recent respiratory illness or diagnosis</td>
<td>Line Scale</td>
<td>Excellent sense of smell</td>
</tr>
</tbody>
</table>

Have you experienced any of the following changes in smell with your recent respiratory illness or diagnosis? (Select all that apply)

- [ ] 1] I cannot smell at all / Smells smell less strong than they did before
- [ ] 2] Smells smell different than they did before (the quality of smell has changed)
- [ ] 3] I can smell things that aren’t there (e.g., I smell burning when nothing is on fire)
- [ ] 4] Sense of smell fluctuates (e.g., comes and goes)

Question Type: Choose n

Optional: Please describe any changes in smell

______________________________
How **blocked** was your nose **BEFORE** your recent respiratory illness or diagnosis?

<table>
<thead>
<tr>
<th>Not at all blocked</th>
<th>Completely blocked</th>
</tr>
</thead>
</table>

(Place a mark on the scale above)

How **blocked** was your nose **DURING** your recent respiratory illness or diagnosis?

<table>
<thead>
<tr>
<th>Not at all blocked</th>
<th>Completely blocked</th>
</tr>
</thead>
</table>

(Place a mark on the scale above)

The following questions are related to your sense of **taste**. For example sweetness, sourness, saltiness, bitterness experienced in the mouth.

Rate your ability to **taste** **BEFORE** your recent respiratory illness or diagnosis

<table>
<thead>
<tr>
<th>No sense of taste</th>
<th>Excellent sense of taste</th>
</tr>
</thead>
</table>

(Place a mark on the scale above)

Rate your ability to **taste** **DURING** your recent respiratory illness or diagnosis

<table>
<thead>
<tr>
<th>No sense of taste</th>
<th>Excellent sense of taste</th>
</tr>
</thead>
</table>

(Place a mark on the scale above)

Optional: Have you experienced changes to **specific tastes** with your recent respiratory illness or diagnosis? (Select all that apply)

- [ ] [1] Sweet
- [ ] [2] Salty
- [ ] [3] Sour
- [ ] [4] Bitter
- [ ] [5] Savory/Umami

Optional: Describe any **changes in taste** during your recent respiratory illness or diagnosis.

The following questions are related to other sensations in your mouth, like burning, cooling, or tingling. For example chili peppers, mint gum or candy, or carbonation.

Rate your **ability to feel these other sensations** **BEFORE** your recent respiratory illness or diagnosis.

<table>
<thead>
<tr>
<th>Not sensitive at all</th>
<th>Very sensitive</th>
</tr>
</thead>
</table>

(Place a mark on the scale above)

Rate your **ability to feel these other sensations** **DURING** your recent respiratory illness or diagnosis

<table>
<thead>
<tr>
<th>Not sensitive at all</th>
<th>Very sensitive</th>
</tr>
</thead>
</table>

(Place a mark on the scale above)
Optional: Describe any changes in these other sensations during your recent respiratory illness or diagnosis.

Question Type: Comment

Optional: Think about a food or beverage you consume regularly - for example, your morning coffee or tea or a piece of fruit you have each day. Has the taste, smell, or flavor changed with your recent respiratory illness or diagnosis? If so, please describe how and be sure to indicate which food or beverage you are describing.

Question Type: Comment

Optional: Is there anything else you would like to tell us about how your recent respiratory illness or diagnosis has affected your sense of smell, taste, and flavor?

Question Type: Comment

Have you recovered from your recent respiratory illness or diagnosis? (For example you no longer have a cough, fever, or shortness of breath.)

Question Type: Choose only 1
Branching: if [0]=checked, then go to Section 3) General Health Information

The next section of this survey is focused on your experiences of smell, taste, and food flavor after your recovery from your recent respiratory illness or diagnosis.

Rate your ability to smell AFTER your recovery

Question Type: Line Scale

How blocked was your nose AFTER your recovery

Question Type: Line Scale

Rate your ability to taste AFTER your recovery

Question Type: Line Scale
Rate your ability to feel these other sensations like burning, cooling, and tingling AFTER your recovery.

Not sensitive at all

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Very sensitive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

(Place a mark on the scale above)

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Question Type: Line Scale

How were you directed to this survey?

- [ ] Clinician or healthcare professional
- [ ] Media (social media, print, radio, tv, etc)
- [ ] Word of mouth
- [ ] Other

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The next section of this survey will ask some optional questions about your habits and general health.

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. General Health Information

**Optional:** Have you smoked at least 100 combustible cigarettes or cigars in your entire life?

- [ ] No
- [ ] Yes
- [ ] Prefer not to say
- [ ] Don't know

Question Type: Choose only 1

**Optional:** During the past 30 days, on how many days did you smoke combustible cigarettes or cigars?

Question Type: Numeric

**Optional:** Have you ever used an e-cigarette ("vaped"/"Juuled") even one time? (E-cigarettes are battery-powered devices that usually contain liquid nicotine, and do not produce smoke.)

Question Type: Choose only 1

**Optional:** During the past 30 days, on how many days did you use an e-cigarette?

Question Type: Numeric (range 0-30; integer)

Did you have any of the following in the 6 months prior to your recent respiratory illness or diagnosis? (Select all that apply)

- [ ] High blood pressure
- [ ] Heart disease (heart attack or stroke)
- [ ] Diabetes (high blood sugar)
- [ ] Obesity
- [ ] Lung disease (asthma/COPD)
- [ ] Head trauma
- [ ] Neurological disease
- [ ] Cancer that required chemotherapy or radiation
- [ ] Cancer that did NOT require chemotherapy or radiation
- [ ] Chronic sinus problems
- [ ] Seasonal allergies/hay fever
- [ ] None

Question Type: Choose n

**Optional:** Any other medical conditions that you would like to mention?

Question Type: Comment

**Optional:** Which medication(s) do you take regularly? For example, medications for pain, blood pressure, thyroid function, anti-viral, etc.

Question Type: Comment
You have now completed the survey and may close your browser. Thank you for your time!

**Optional:** Is there anything we didn't ask about that you would like to share with us?

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**Re-contact**

We may want to re-contact you for follow up research on this topic. **Is it okay if our team or other researchers re-contact you to participate in future research**? By saying yes, you agree that we can share your email address with other researchers for this purpose.

- [ ] Yes
- [ ] No

---

**End of Test**

Please provide your full email address, so you can be contacted for future studies by our team or other researchers.

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**Notes**

- "In which year (YYYY) were you born?" -- value must be 1900 or greater
- "What date did you first notice symptoms of your recent respiratory illness? Provide your best guess or leave blank if you do not remember. Click the box below to display a calendar" -- format (mm/dd/yyyy)
- "Have you been diagnosed with COVID-19?" -- if [8] Other was selected, a comment is required
- "Were you diagnosed with any other respiratory illnesses (not COVID-19) in the last two weeks? (Select all that apply)" -- if [6] None was selected, no other options can be selected.
- "Have you had any of the following symptoms with your recent respiratory illness or diagnosis? (Select all that apply)" -- if [17] No symptoms was selected, no other options can be selected.
- "Rate your ability to smell BEFORE your recent respiratory illness or diagnosis" -- Line Scale Range 0-100, intervals of 1. All following line scales formatted similarly
- "OPTIONAL: During the past 30 days, on how many days did you smoke combustible cigarettes or cigars?" and "OPTIONAL: During the past 30 days, on how many days did you use an e-cigarette?" -- value must be between 0-30
- "Did you have any of the following in the 6 months prior to your recent respiratory illness or diagnosis? (Select all that apply)" -- if [12] None was selected, no other options can be selected.