

Participant identifier

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Participant initials

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Baseline CRF

Introduction		
1.	Date of birth (DD/MMM/YYYY):	_ _ / _ _ _ / _ _ _ _
2.	Sex	Male / Female / Other
3.	Are you a current smoker?	Yes ☐ No ☐
3a)	Are you an ex-smoker?	Yes ☐ No ☐
3.	Do you have any of the following co-morbidities/conditions:	
4a)	• Asthma, COPD or other lung disease	Yes ☐ No ☐
4b)	• Diabetes	Yes ☐ No ☐
4c)	• Heart problems (e.g. angina, heart attack, heart failure, atrial fibrillation, valve problems)	Yes ☐ No ☐
4d)	• High blood pressure for which you are taking medications	Yes ☐ No ☐
4e)	• Liver disease	Yes ☐ No ☐
4f)	• Stroke or other neurological problem	Yes ☐ No ☐
5.	Are you taking ramipril, lisinopril, perindopril, captopril or enalapril?	Yes ☐ No ☐

Symptoms		
Please rate the following symptoms today:		
6.	Fever	No problem / Mild problem / Moderate problem / Major problem
7.	Cough	No problem / Mild problem / Moderate problem / Major problem
8.	Shortness of breath	No problem / Mild problem / Moderate problem / Major problem
9.	Muscle ache	No problem / Mild problem / Moderate problem / Major problem
10.	Nausea / Vomiting	No problem / Mild problem / Moderate problem / Major problem
11.	What date did you start to feel unwell with this illness (DD/MMM/YYYY)?	_ _ / _ _ _ / _ _ _ _
12.	Have you taken antibiotics since your illness started?	Yes ☐ No ☐

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Baseline CRF

Healthcare Services		
13.	Have you had contact with the following healthcare services since your illness started? Please answer Yes or No.	
13a)	GP	Yes ☐ No ☐
13b)	Other primary Care services (e.g. walk-in services/pharmacist)	Yes ☐ No ☐
13c)	NHS 111	Yes ☐ No ☐
13d)	A&E	Yes ☐ No ☐
13e)	Other	Yes ☐ No ☐
13e. i)	If 'Other' please specify: _____	

Completed by: Print nameSignDate __/__/____