Appendix 1. CPCCR worksheet

Field Name	Values
Date of symptom onset	Date
Date of symptom improvement	Date (if applicable)
Date of symptom resolution	Date (if applicable)
Positive viral test (PCR)	Yes/No
	If Yes, Date
Negative viral test (PCR)	Yes/No
	If Yes, Date
Positive serology test	Yes/No
	If Yes, Date
Negative serology test	Yes/No
	If Yes, Date of 1st dose
Hospitalized	No/Yes
ICU	No/Yes
SOB	No/Yes
Cough	No/Yes
Chest discomfort	No/Yes
Palpitations	No/Yes
Dizziness	No/Yes
Brain Fog	No/Yes
Headache	No/Yes
Anosmia	No/Yes
Nausea or vomiting	No/Yes
Dysgeusia	No/Yes
Abd pain	No/Yes
Diarrhea	No/Yes
Fever	No/Yes
Fatigue	No/Yes
Myalgia	No/Yes
Nasal/facial congestion	No/Yes
Blood clots	No/Yes
Skin rash	No/Yes