The questions from the survey used in this study.

| Question                                                                 | Response options                                                                 |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Marital status (tick one or more options)                                | □ Married □ Partner □ Divorced or separated □ Widow/widower                        |
| Were you born in Sweden?                                                 | □ Yes □ No                                                                        |
| Was your mother born in Sweden?                                          | □ Yes □ No                                                                        |
| Was your father born in Sweden?                                          | □ Yes □ No                                                                        |
| Which in your highest educational level?                                 | □ Elementary school □ Upper secondary school □ Vocational college at least 2 years □ University at least 3 years |
| Have/do you smoked cigarettes?                                          | □ Yes, currently □ Yes, in the past, but I quit at least 6 months ago □ No, never |
| Do you use snuff?                                                       | □ Yes □ No                                                                        |
| What is your height (cm)?                                                | ..........                                                                        |
| What is your weight (kg)?                                                | ..........                                                                        |
| Have you had any of following diseases diagnosed by a doctor (before you fell ill with COVID-19)? Tick one or more options. | □ Hypertension □ Other heart disease □ Diabetes mellitus (type 1 or 2) □ Lung disease □ Liver disease □ Stroke □ Anxiety □ Depression □ Chronic pain (in the last year, symptoms for at least 3 months) □ Cancer with/without treatment □ Other disease with immunosuppressive treatment □ Hypo-/hyperthyroidism □ No |
| How would you rate your physical fitness relative to that among other people of the same age? | □ Better □ Same □ Worse |
| How would you rate your physical fitness before COVID-19 relative to that among other people of the same age? | □ Better □ Same □ Worse |
| Did you have any of these symptoms at onset? Tick one or more options. | □ Fever □ Breathing problems □ Muscle/joint pain □ Sore throat □ Headache □ Impaired sense of smell and taste □ Nasal congestion |
| Symptoms                                                                 | One Month After COVID-19 Diagnosis | Three Months After COVID-19 Diagnosis |
|--------------------------------------------------------------------------|------------------------------------|--------------------------------------|
| Cough                                                                    |                                    |                                     |
| Eye irritation                                                            |                                    |                                     |
| Skin rash                                                                |                                    |                                     |
| Pain in the chest                                                         |                                    |                                     |
| Heart palpitation                                                         |                                    |                                     |
| Anxiety                                                                  |                                    |                                     |
| Depression                                                               |                                    |                                     |
| Gastrointestinal symptoms (nausea, diarrhea, stomach pain)                |                                    |                                     |
| Fatigue                                                                  |                                    |                                     |
| Dizziness                                                                |                                    |                                     |
| No symptoms                                                               |                                    |                                     |
| Fever                                                                    |                                    |                                     |
| Breathing problems                                                        |                                    |                                     |
| Muscle/joint pain                                                         |                                    |                                     |
| Sore throat                                                               |                                    |                                     |
| Headache                                                                 |                                    |                                     |
| Impaired sense of smell and taste                                        |                                    |                                     |
| Nasal congestion                                                          |                                    |                                     |
| Cough                                                                     |                                    |                                     |
| Eye irritation                                                            |                                    |                                     |
| Skin rash                                                                 |                                    |                                     |
| Pain in the chest                                                         |                                    |                                     |
| Heart palpitation                                                         |                                    |                                     |
| Anxiety                                                                   |                                    |                                     |
| Depressed mood                                                            |                                    |                                     |
| Gastrointestinal symptoms (nausea, diarrhea, stomach pain)                |                                    |                                     |
| Fatigue                                                                   |                                    |                                     |
| Dizziness                                                                 |                                    |                                     |
| No symptoms                                                               |                                    |                                     |
| Question                                                                 | Options                                                                                       |
|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| **Did you have any of these symptoms six months after your COVID-19 diagnosis?** | Fever, Breathing problems, Muscle/joint pain, Sore throat, Headache, Impaired sense of smell and taste, Nasal congestion, Cough, Eye irritation, Skin rash, Pain in the chest, Heart palpitation, Anxiety, Depressed mood, Gastrointestinal symptoms (nausea, diarrhea, stomach pain), Fatigue, Dizziness, No symptoms |
| **Do you currently, twelve months after your COVID-19 diagnosis, have any of the symptoms that started in connection with the acute infection?** | Fever, Breathing problems, Muscle/joint pain, Sore throat, Headache, Impaired sense of smell and taste, Nasal congestion, Cough, Eye irritation, Skin rash, Pain in the chest, Heart palpitation, Anxiety, Depressed mood, Gastrointestinal symptoms (nausea, diarrhea, stomach pain), Fatigue, Dizziness, No symptoms |
| **How do you experience your general health now?** | ![Scale from 100 to 0] 100 means that you are in the best possible health, 0 means that you are in the worst possible health. Tick one option. |
| **How did you experience your general health before COVID-19?** | ![Scale from 100 to 0] 100 means that you were in the best possible health, 0 means you were in the worst possible health. Tick one option. |

![Scale from 100 to 0] 100 means that you are in the best possible health, 0 means that you are in the worst possible health. Tick one option.

![Scale from 100 to 0] 100 means that you were in the best possible health, 0 means you were in the worst possible health. Tick one option.
| What do you do (primary occupation)? Tick one option. | ☐ Working ☐ Parental leave ☐ Sick leave ☐ Unemployed/looking for a job ☐ Retired ☐ Student |
| If you are working, what is your primary occupation? | …… |
| Have you sought healthcare (including phone call to a healthcare advisor, visit to primary care or secondary care) due to persistent symptoms after COVID-19? | ☐ Yes ☐ No |
| A) Have you been on sick leave (with a doctor’s certificate) due to COVID-19 or its consequences? | ☐ Yes ☐ No |
| B) If “Yes,” for how many weeks? | …………… |
| A) Were you on sick leave (with a doctor’s certificate) before the pandemic (during 2019)? | ☐ Yes ☐ No |
| B) If “Yes,” for how many weeks? | ……… |
| How would you rate your work ability at the moment, one year after your COVID-19 diagnosis? Please tick one option. Zero is the worst and ten is the best work ability. | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 |
| How would you rate your work ability before the COVID-19 infection? Please tick one option. Zero is the worst and ten is the best work ability. | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 |