**THE COVIDORA STUDY**

**CRF**

## INFORMATION FOR THE PATIENT

**We will ASK YOU QUESTIONS in order to gather information about**

**- your medical history**

**- your recent symptoms**

**- about the quality of your ABILITY TO SMELL AND YOUR TASTE.**

**Answer freely based on your current condition.**

**Take time to think about each question before you give your answer. If you don't understand a question, ask us to explain it to you.**

## IDENTIFICATION PATIENT

**First letter of the last name :** __

**First letter of the first name:** __

**Date of birth:** |__|__| **(day)** |__|__| **(month)** |__|__|__|__| **(year)**

**Age of the patient on the day of inclusion:** |__|__| **(years)**

**Sex:** ☐ Female or ☐ Male

**Date of inclusion:** |__|__| **(day)** |__|__| **(month)** |__|__|__|__| **(year)**

**Name of the investigator:**

## FIRST VISIT
## Teleconsultation or face-to-face consultation
## (to be carried out within 3 days of a positive COVID-19 diagnosis)

**Date of the consultation:** |__|__| **(day)** |__|__| **(month)** |__|__|__|__| **(year)**

## CENTRE for inclusion = Centre number |__|__| (see the list below)?

CENTRE 1= Service ORL Lariboisière (Dr Hautefort),
CENTRE 2= Service ORL Henri Mondor (Dr Bartier et Dr Bequignon)
CENTRE 3= Service ORL Kremlin Bicêtre (Pr Papon et Dr Nevoux)
CENTRE 4= Service ORL La Pitié Salpetrière (Pr Nguyen)
CENTRE 5= Service Maladies Infectieuses, Hôtel Dieu (Pr Salmon)
CENTRE 6= Service ORL Centre Hospitalier Intercommunal de créteil (Pr Prulières Escabasse)
CENTRE 7= Hôpital Fondation Rotschild (Dr Corré)
CENTRE 8 =Service ORL, CHU de Strasbourg (Pr Debry)
CENTRE 9 = Service ORL Hospices civiles de Lyon (Pr Tringali)
CENTRE 10= Service ORL Hôpital Edouard Herriot-HCL Lyon (Pr Truy)
CENTRE 11= Service ORL Chu de Caen (Dr Patron)
CENTRE 12= Service ORL CHU Toulouse (Pr Serrano et Dr Debonnecaze)
CENTRE 13=Service ORL Institut Arthur Vernes, Paris (Dr Lecanu)
CENTRE 14= Service ORL CHU Nantes (Pr Malard)
CENTRE 15= Service d'ORL, CHU de La Conception, Marseille (Pr Michel)
CENTRE 16= Institut Universitaire de la Face et du Cou, Nice (Dr Vandersteen)
CENTRE 17= Service ORL Hôpital Saint-Philibert GHICL (Dr E Bartaire)
CENTRE 18 =Service ORL Hôpital Saint-Vincent de Paul GHICL / Faculté Libre de Médecine de Lille (Dr Deraedt)
CENTRE 19= Service ORL et chirurgie cervico-faciale CHU de Clermont-Ferrand (Dr Saroul)
CENTRE 20 = Service ORL, CHRU Nancy (Dr Rumeau)
CENTRE 21= Service ORL, CHU de Poitiers (Pr Dufour et Dr Carsuzaa)
CENTRE 22= Service ORL, Hôpital FOCH, Suresnes (Pr Hans)
CENTRE 23= Service ORL, CHU de Bordeaux, (Pr De Gabory)
CENTRE 24= Service ORL, Cochin (Dr Lacroix)

## ACTUAL SITUATION

*First of all, where is the patient on the date of Visit 1?*
At home 0 At home with oxygen 1 Medical unit 2 ICU 3 Deceased 4

- At home ☐
- At home with oxygen☐
- Hospitalized in Medical unit with oxygen ☐
- Hospitalized in ICU ☐
- The patient is deceased ☐

If death, under what circumstances? …….

## CARACTERISTIQUES EPIDEMIOLOGIQUES

### Weight and Height

Weight |__|__|__| kg Height |__|,|__|__| m MBI |__|__|,|__| kg/m2

### Profession

……

### Tabacco

**Do you smoke or have you ever been a smoker ?** ☐ yes ☐ no
Current : 0 no 1 yes Consumption : |__|__|__|
weaned : 0 no 1 yes Number of years of weaning: |__|__|__|

### General history

0 non 1 oui

- Allergies
  - **Do you have any known allergies?** ☐ yes ☐ no
  - If the answer is yes, which ones: ……
- Chronic illness
  - **Do you have a history of immunosuppression?** ☐ yes ☐ no
  - **Do you have a history of chronic illness?** ☐ yes ☐ no
  - If the answer is yes, which ones**:**
    ☐ Diabetes ☐ Hypertension ☐ Neoplasia: ……
    ☐ Renal insufficiency ☐ Inflammatory or degenerative neurological pathology
  - **Do you have a history of autoimmune disease (lupus, polyarthritis) ?** ☐ yes ☐ no

## ENT history

**Do you have an ENT history?** ☐ yes ☐ no

- Rhinological history
  - If the answer is yes, which ones:

    ☐ **Allergic rhinitis:** 0 no 1 proven 2 suspected 3 NA

    If the answer is yes, which allergen is involved (mite, pollen?) .....

    *If allergic to pollens* : do you think you have started your seasonal allergy attack (appearance of your usual symptoms?) 0 no 1 yes

    ☐ **Chronic rhinosinusitis without polyps:** 0 no 1 yes

    ☐ **Chronic rhinosinusitis with polyps** 0 no 1 yes

    ☐ **Radiotherapy covering the head area :** 0 no 1 yes

    ☐ **Chemotherapy :** 0 no 1 yes

- History of anosmia (complete loss of smell))

  **Do you have a history of complete loss of smell (anosmia) ?** 0 no 1 yes

  If the answer is yes, are the symptoms old and permanent (older than 3 months)? 0 no 1 yes

- History of head trauma

  **Do you have a history of severe head trauma?**

  - 0 no 1 yes

## Medication

*0 non 1 oui*

**Are you taking any medication (including nasal spray) ?** 0 no 1 yes

If the answer is yes, which ones: ……

# CLINICAL FEATURES

## Date of onset of first COVID symptoms

**When did you first experience symptoms attributable to COVID-19?**____/ ____ / ____

## Olfaction disorders

Do you have a sense of smell disorder. (Do you have difficulty smelling odors?). 0 no 1 yes

| | |
|---|---|
| **If the answer is yes, when did it start?** | ____/ ____ / ____ |
| Onset of the symptom<br>0 gradually 1 suddenly<br>**Did the smell problems appear gradually or suddenly?** | ☐ Gradually<br>☐ Suddenly |

| | |
|---|---|
| Inaugural nature of the symptom<br>0 no 1 yes<br>**Were the problems with your sense of smell the first of your symptoms in isolation?**<br>**If the answer is no, has it been:**<br>**- Concomitant with other symptoms?**<br>**- Preceded by classical symptoms of COVID-19 (fever >38°, cough?)**<br>**- Preceded by minor symptoms (fatigue, aches, headaches?)** | ☐ Yes ☐ No<br><br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| Quantitative dysosmia<br>1 partial (= hyposmia)<br>2 total (= anosmia)<br>**Is your loss of smell partial or total?** | ☐ Partial ☐ Total |
| Parosmia<br>0 no 1 yes<br>**Did you ever perceive a smell that did not correspond to the olfactory stimulation? (For example, coffee smells like burnt rubber)** | ☐ Yes ☐ No |
| Phantosmia<br>0 no 1 yes<br>**Have you ever perceived a smell without any olfactory stimulation?** | ☐ Yes ☐ No |
| **Can you accurately smell the scent of:**<br>0 no 1 yes<br>• **Cinnamon ?**<br>• **Cumin ?**<br>• **Cloves ?**<br>• **Vanilla ?**<br>• **Vinegar ?** | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |

## Evolution of the olfaction disorder

**How long has your loss of smell been evolving in days** ?……

## Rhinological symptoms

| | |
|---|---|
| Rhinorrhea<br>If yes, concomitant to the smell disorder?<br>0 no 1 yes<br>**Did you have a runny nose?**<br>0 no 1 yes<br>**If so, was it concomitant with the loss of smell?** | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| Nasal obstruction<br>0 no 1 yes<br>**Did you have the feeling that your nose was completely blocked?** | ☐ Yes ☐ No |
| Nasal hyperreactivity<br>0 no 1 yes<br>**Did you have an itchy nose with the urge to sneeze +/- sneezing?** | ☐ Yes ☐ No |

| | |
|---|---|
| Nasal paresthesia (burning sensation, intranasal pain)<br>**Did you experience a sensation of burning nose, tingling, pain?** | ☐ Yes ☐ No |
| Other symptoms<br>0 no 1 yes<br>**Did you experience any other rhinologic symptoms?**<br>If the answer is yes, which ones: | ☐ Yes ☐ No<br>……<br>…… |

## Taste disorder

| | |
|---|---|
| Dysgueusia<br>0 no 1 yes<br>**Did you experience a taste disorder?**<br>**If the answer is yes:**<br>- **Was it about the flavors of the food?**<br>- **Was it about salty/sweet/bitter/sour?** | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| **Can you recognize:**<br>0 no 1 yes<br>• **Salty taste ?**<br>• **Sweet taste ?**<br>• **Bitter taste ?**<br>• **Acidic taste ?** | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |

## Other symptoms of COVID-19

**Did you experience: ….?** 0 no 1 yes

| | | | |
|---|---|---|---|
| • **Fever** | ☐ Yes ☐ No | • **Difficulty breathing (dyspnea?)** | ☐ Yes ☐ No |
| • **Coughing** | ☐ Yes ☐ No | • **Diarrhea** | ☐ Yes ☐ No |
| • **Headache** | ☐ Yes ☐ No | • **Nausea/vomiting** | ☐ Yes ☐ No |
| • **Fatigue** | ☐ Yes ☐ No | • **Dizziness** | ☐ Yes ☐ No |
| • **Muscle pain** | ☐ Yes ☐ No | • **Chest pain/oppression** | ☐ Yes ☐ No |
| • **Sore throat** | ☐ Yes ☐ No | • **Joint pain** | ☐ Yes ☐ No |
| • **Conjunctivitis** | ☐ Yes ☐ No | • **Skin rash** | ☐ Yes ☐ No |
| • **Laryngitis** | ☐ Yes ☐ No | • **Other...** | ☐ Yes ☐ No |
| | | **If the answer is yes, which one** : | …… |

## Diagnosis of COVID-19

Contagion
0 no 1 yes
**Have you been in contact with a known case of COVID-19?** ☐ Yes ☐ No

Screening
0 no 1 yes unless otherwise specified

| | |
|---|---|
| Swab<br>• **Have you been swabbed for COVID-19?**<br>**If the answer is yes :**<br>**- Nasal or pharyngeal swab (in the throat)**<br>**- On what date?**<br>**- What was the test result? 0 negative 1 positive**<br>**Have you been swabbed a second time for COVID-19?**<br>**If the answer is yes :**<br>**- Nasal or pharyngeal swab (in the throat)**<br>**- On what date?**<br>**- What was the test result? 0 negative 1 positive** | ☐ Yes ☐ No<br><br>☐ Nasal ☐ Throat<br>____/ ____ / ____<br>☐ Negative ☐ Positive<br>☐ Yes ☐ No<br><br>☐ Nasal ☐ Throat<br>____/ ____ / ____<br>☐ Negative ☐ Positive |
| Imaging<br>• **Did you have a chest CT-scan?**<br>**- If so, on what date?**<br>**- What was the result?**<br>**- If positive, what were the signs suggestive of COVID?** | ☐ Yes ☐ No<br>☐ Negative ☐ Positive<br>**.....** |

# SECOND VISIT
## Teleconsultation or face-to-face consultation
## (to be carried out between days 7 and 10 of a positive COVID-19 diagnosis)

**Date of the consultation: |__|__| (jour) |__|__| (mois) |__|__|__|__| (année)**

## ACTUAL SITUATION

***First of all, where is the patient on the date of Visit 2 ?***
At home 0 At home with oxygene 1 Medical unit 2 ICU 3 Deceased 4

- At home ☐
- At home with oxygen☐
- Hospitalized in Medical unit with oxygene ☐
- Hospitalized in ICU ☐
- The patient is deceased ☐

If death, under what circumstances? …….

**Management evolution**

0 no 1 yes unless otherwise specified

| | |
|---|---|
| • **Have you been hospitalized?**<br>**If yes, in which type of medical unit?** | ☐ Yes ☐ No<br>…… |

**Evolution of other symptoms of COVID-19**

**Since first visit, did you experience : ?** 0 non 1 oui

| | | | |
|---|---|---|---|
| • **Fever** | ☐ Yes ☐ No | • **Difficulty breathing (dyspnea?)** | ☐ Yes ☐ No |
| • **Coughing** | ☐ Yes ☐ No | • **Diarrhea** | ☐ Yes ☐ No |
| • **Headache** | ☐ Yes ☐ No | • **Nausea/vomiting** | ☐ Yes ☐ No |
| • **Fatigue** | ☐ Yes ☐ No | • **Dizziness** | ☐ Yes ☐ No |
| • **Muscle pain** | ☐ Yes ☐ No | • **Chest pain/oppression** | ☐ Yes ☐ No |
| • **Sore throat** | ☐ Yes ☐ No | • **Joint pain** | ☐ Yes ☐ No |
| • **Conjunctivitis** | ☐ Yes ☐ No | • **Skin rash** | ☐ Yes ☐ No |
| • **Laryngitis** | ☐ Yes ☐ No | • **Other...** | ☐ Yes ☐ No |
| | | **If the answer is yes, which one** : | …… |

## Si pas de perte d'odorat dépistée à la 1ère visite, reposez les questions suivantes :

**Since the last consultation, have you noticed the appearance of a problem with your sense of smell** (do you have difficulty smelling odors?) ☐ Yes ☐ No

**Olfaction disorders**

| | |
|---|---|
| **If the answer is yes, when did it start?** | ____/ ____ / ____ |
| Onset of the symptom<br>0 gradually 1 suddenly<br>**Did the smell problems appear gradually or suddenly?** | ☐ Gradually<br>☐ Suddenly |
| Inaugural nature of the symptom<br>0 no 1 yes<br>**Were the problems with your sense of smell the first of your symptoms in isolation?**<br>**If the answer is no, has it been:**<br>**- Concomitant with other symptoms?**<br>**- Preceded by classical symptoms of COVID-19 (fever >38°, cough?)**<br>**- Preceded by minor symptoms (fatigue, aches, headaches?)** | ☐ Yes ☐ No<br><br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| Quantitative dysosmia<br>1 partial (= hyposmia) 2 total (= anosmia)<br>**Is your loss of smell partial or total?** | ☐ Partial ☐ Total |
| Parosmia<br>0 no 1 yes<br>**Did you ever perceive a smell that did not correspond to the olfactory stimulation? (For example, coffee smells like burnt rubber)** | ☐ Yes ☐ No |

| | |
|---|---|
| Phantosmia<br>0 no 1 yes<br>**Have you ever perceived a smell without any olfactory stimulation?** | ☐ Yes ☐ No |
| **Can you accurately smell the scent of :**<br>0 no 1 yes<br>• **Cinnamon ?**<br>• **Cumin ?**<br>• **Cloves ?**<br>• **Vanilla ?**<br>• **Vinegar ?** | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |

## Evolution of the olfaction disorder

**How long has your loss of smell been evolving in days** ?……

## Rhinological symptoms

| | |
|---|---|
| Rhinorrhea<br>If yes, concomitant to the smell disorder?<br>0 no 1 yes<br>**Did you have a runny nose?**<br>0 no 1 yes<br>**If so, was it concomitant with the loss of smell?** | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| Nasal obstruction<br>0 no 1 yes<br>**Did you have the feeling that your nose was completely blocked?** | ☐ Yes ☐ No |
| Nasal hyperreactivity<br>0 no 1 yes<br>**Did you have an itchy nose with the urge to sneeze +/- sneezing?** | ☐ Yes ☐ No |
| Nasal paresthesia (burning sensation, intranasal pain)<br>**Did you experience a sensation of burning nose, tingling, pain?** | ☐ Yes ☐ No |
| Other symptoms<br>0 no 1 yes<br>**Did you experience any other rhinologic symptoms?**<br>If the answer is yes, which ones: | ☐ Yes ☐ No<br>…… |

## Taste disorder

| | |
|---|---|
| Dysgueusia<br>0 no 1 yes<br>**Did you experience a taste disorder?**<br>**If the answer is yes:**<br>- **Was it about the flavors of the food?**<br>- **Was it about salty/sweet/bitter/sour?** | ☐ Yes ☐ No<br><br>☐ Yes ☐ No<br>☐ Yes ☐ No |

| | |
|---|---|
| **Can you recognize:**<br>0 no 1 yes<br>• **Salty taste ?**<br>• **Sweet taste ?**<br>• **Bitter taste ?**<br>• **Acidic taste ?** | <br><br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |

## Other symptoms of COVID-19

**Did you experience: ….?** 0 no 1 yes

| | | | |
|---|---|---|---|
| • **Fever** | ☐ Yes ☐ No | • **Difficulty breathing (dyspnea?)** | ☐ Yes ☐ No |
| • **Coughing** | ☐ Yes ☐ No | • **Diarrhea** | ☐ Yes ☐ No |
| • **Headache** | ☐ Yes ☐ No | • **Nausea/vomiting** | ☐ Yes ☐ No |
| • **Fatigue** | ☐ Yes ☐ No | • **Dizziness** | ☐ Yes ☐ No |
| • **Muscle pain** | ☐ Yes ☐ No | • **Chest pain/oppression** | ☐ Yes ☐ No |
| • **Sore throat** | ☐ Yes ☐ No | • **Joint pain** | ☐ Yes ☐ No |
| • **Conjunctivitis** | ☐ Yes ☐ No | • **Skin rash** | ☐ Yes ☐ No |
| • **Laryngitis** | ☐ Yes ☐ No | • **Other...** | ☐ Yes ☐ No |
| | | **If the answer is yes, which one** : | …… |

## If loss of smell is detected at the first visit, ask the following questions:

## Treatment received for loss of smell / Rehabilitation

**Have you received treatment for your loss of smell ?** ☐ Yes ☐ No

**If yes, which ones ?** 0 non 1 oui

| | Oui / Non | **Si oui lequel ?** | **Si oui durée ?** |
|---|---|---|---|
| **Treatment with systemic corticosteroid therapy (oral) ?** | ☐ Yes ☐ No | …. | …… |
| **Local treatment ?**<br>• Nose washes with saline solution<br>• Local corticosteroid therapy<br>• Other treatments ? | <br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No | <br>….<br>…. | ……. |
| **Anti-COVID treatment (plaquenil, zithromax , autre antiviral)** | ☐ Yes ☐ No | …. | ……. |

- **Have you done olfactory rehabilitation?** ☐ Yes ☐ No
- **If yes, for how long in days : ……..**

**Evaluation of olfactory recovery if disorder already described initially**

- **How far are we from the beginning of the disorder of the sense of smell (in days) ?**: …….

- **To date, have you recovered in terms of olfaction?** ☐ Yes ☐ No
  **If so, in your opinion, have you recovered partially or totally?** ☐ Partially ☐ Totally
  0 partially 1 totally
  **If so, how would you rate your recovery on a scale of 0 to 10**
  (10= complete recovery) ?.....

- **Have you ever perceived a smell that did not correspond to the olfactory stimulation (parosmia)?**
  ☐ Yes ☐ No

- **Have you ever perceived a smell without any olfactory stimulation (phantosmia)?**
  ☐ Yes ☐ No

- **How long did it take for your smell to recover in days?**

| [0-5[ days | [5-10[ days | [10-15[ days | [15-30[ days | More than a month |
|---|---|---|---|---|
| | | | | |