Supplemental Data S1

Questionnaire for participants

1. Surname, Name_____
2. Telephone number_____
3. Age _____
4. Height/weight _____
5. Allergy (indicate if any) _____

6. Indicate if you have any of those complaints

□ Fatigue □ Increased sweetness □ Dizziness
□ Increased/decreased blood pressure □ Palpitation
□ Pain in muscle □ Syncope
□ Pain in epigastric region □ Sleep disturbances
□ Other (indicate)_____

7. Chronic diseases (yes/no, if yes, indicate which)
(eg. Diabetes mellitus, hypertension, asthma, gastritis, etc.)
_____
_____

8. Please indicate the period of coronavirus infection (day, month, duration in days)
_____
_____

9. Were you hospitalized during the infection period (yes/no)?
_____
_____
_____

10. Did you have chest Xray or chest CT during the infection period

□ Yes □ No

11. Please indicate any medications you take currently (if any)?
_____
_____
_____
_____
_____

Note. Data was collected from 312 patients with post-COVID-19