Appendix 1 (as supplied by the authors): Anosmia – telephone questionnaire for patients who got tested for COVID-19

Record ID _____

SCRIPT INTERVIEW

Hello, my name is [NAME OF INTERVIEWER] and I work for the CIUSSSE de l'Estrie-CHUS. I would like to speak with [MR or MRS] [NAME OF PATIENT].

*** IF THE SPEAKER IS NOT THE PATIENT**

**** IF THERE ARE OTHER MEMBERS OF THE FAMILY THAT WERE TESTED FOR COVID-19, SPEAK WITH THEM AFTERWARDS.**

Hello, [MR or MRS] [NAME OF PATIENT] my name is [NAME OF INTERVIEWER] and I work for the CIUSSSE de l'Estrie-CHUS. We are conducting clinical surveillance of COVID-19 for all persons over 18 years of age who got tested for COVID-19, whether the result is positive or negative. We are not authorized to divulge test results. A Public Health Official will contact you with your results.

Our research team would like to better understand the COVID-19 virus which could allow for persons affected by the virus to receive better health services.

During this call, we will be asking you questions regarding your health. Your answers will not have any incidence on the quality of health services that you receive. Our hope is that it will permit physicians and other health care professionals to be better informed about this virus.

This call will should take approximately 20 minutes of your time. Your answers are confidential and will be stored securely for 25 years in accordance with the current research policies in effect. The information relayed to the health care workers will be anonymous, meaning that they will not be able to identify you.

Do you have any questions?

Before starting the questionnaire, I would also like to confirm your consent for the use of the data for research purposes. More specifically, your information is essential for the public health but could also be pertinent for other current or future researches, that would be related to the coronavirus. Theses researches will all be evaluated by a research ethics committee. The projects would not use information that would permit you to be identified, such as your name, address or phone number.

Do you have any questions regarding the secondary use of the research data?

Do you consent to the use of secondary data, that excludes your name, address and phone number? ○ No ○ Yes

INSTRUCTIONS FOR THE INTERVIEWER:

- If a patient refuses the use of the data, take note of the patient's name and telephone number in a confidential file, that will later be sent to Dr Louis Valiquette once all calls are completed.
- If a patient asks for more information regarding the use of their secondary data, they may contact the President of the Ethics Committee at 819-346-1110 extension 12856.
- Patients who received a positive COVID-19 result may call 819-644-4545 if they have questions pertaining to their diagnostic.
- For those who are still awaiting their results, a Public Health Official will call them when the result is available.
- For more information https://www.inspq.qc.ca/covid-19/outils

Signature of employee completing the questionnaire: _____

Appendix to: Carignan A, Valiquette L, Grenier C, et al. Anosmia and dysgeusia associated with SARS-CoV-2 infection: an age-matched case–control study. *CMAJ* 2020. doi: 10.1503/cmaj.200869.

DEMOGRAPHICS	
Name	_____ First name, Last Name
CIUSSSE-CHUS File number	
Postal code	_____ (999 if unknown)
Date of birth	_____ (01-01-1901 if unknown)
Sex at birth	○ Female ○ Male
Telephone number	

SARS-CoV-2 TEST	
Sample date	_____ (01-01-1901 if unknown)
Site where sample was collected	○ Hôtel-Dieu ○ Asbestos ○ Lac Megantic ○ Granby ○ Windsor ○ Coaticook
SARS-CoV-2 test result	○ Negative ○ Positive

SUMMARY OF CONTACT WITH PATIENT	
Was the patient reached?	○ No ○ Yes
If not, specify the reason	○ Incorrect telephone number ○ 8 unsuccessful attempts ○ Patient is deceased ○ Patient is inapt (excluded from the study) ○ Patient is still hospitalised ○ Other (please precise in space below)
Precise 'Other' reason	
If the patient was reached, was the questionnaire completed?	○ No ○ Yes – Consents to the use of data for research ○ Yes – Refuses the use of data for research
If not completed, specify reason	○ Patient refused ○ Patient is inapt (excluded from the study) ○ Patient is deceased ○ Other (please precise in space below)
Precise 'Other' reason	
Have your received you COVID-19 test results?	○ No ○ Yes **Result** ○ Negative ○ Positive

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Is there another member of your family that has been tested for COVID-19?	○ No ○ Yes * If yes, verify if that person is on the Covid19-Anosmie Listing Calls à faire . If the patient is on the list, inform the current patient that we will speak with [NAME OF FAMILY MEMBER] once the questionnaire is completed
Have you been hospitalised for this condition?	○ No ○ Yes
Are you pregnant?	○ No ○ Yes ○ Not applicable

COMORBIDITIES	
Are you being treated for diabetes?	○ No ○ Yes
RISK FACTORS AND ASSOCIATED CONDITIONS	
What is your smoking status?	○ Active (including occasional) ○ Past smoker ○ Never smoked
If you are a past smoker, have you smoked in the last year?	○ No ○ Yes
Do you vape or smoke e-cigarettes?	○ No ○ Yes
Do you smoke cannabis on a regular basis?	○ No ○ Yes
In the past year, have you inhaled cocaine nasally?	○ No ○ Yes
Have you ever had a traumatic (shock) to the head caused either by a fall, a major hit or a car accident (head-on collision)?	○ No ○ Yes
Have you received a medical diagnostic of seasonal allergies (pollen, hay fever)?	○ No ○ Yes
Have you received a medical diagnostic of animal allergies?	○ No ○ Yes
Do you have nasal congestion all year round?	○ No ○ Yes
Do you have a runny/leaky nose all year round?	○ No ○ Yes
Do you take cortisone in the form of nasal vaporiser on a regular basis? (ex: Nasocort, Nasonex)	○ No ○ Yes – all year ○ Yes – only during allergy season

SIGNS AND SYMPTOMS	
When did your first COVID-19 related symptoms start?	_____ (01-01-1901 if unknown)

During the period of 72 hours BEFORE and AFTER your COVID-19 test, did you have any of the following symptoms?		
	NO	**YES**
Generalized weakness (include fatigue)	o	o
Muscular pain	o	o
Joint pain	o	o
Chest pain	o	o
Shortness of breath	o	o
Dyspnea/Difficulty breathing	o	o
Chills	o	o
Fever > 38° C	o	o
Feverishness (did not take temperature but felt feverish)	o	o
Nasal congestion	o	o
Runny nose	o	o
Sneezing	o	o
Sore throat	o	o
Cough	o	o
Sputum production (phlegm, mucus)	o	o
Loss of appetite	o	o
Nausea	o	o
Vomiting	o	o
Diarrhea (liquid stools)	o	o
Headache	o	o
Conjunctivitis (eye infection)	o	o
Skin rash/lesion or redness	o	o
Change or loss of smell	o	o
Change or loss of taste	o	o
Vertigo or dizziness	o	o
Blurred vision	o	o
Loss of hot/cold facial sensation	o	o
Which one of your symptoms appeared first?	o Generalized weakness o Muscular pain o Joint pain o Chest pain o Shortness of breath o Difficulty breathing o Chills o Fever o Feverishness	

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	○ Nasal congestion ○ Runny nose ○ Sneezing ○ Sore throat ○ Cough ○ Sputum production ○ Loss of appetite ○ Nausea ○ Vomiting ○ Diarrhea (liquid stools) ○ Headache ○ Conjunctivitis (eye infection) ○ Skin rash/lesion or redness ○ Change or loss of smell ○ Change or loss of taste ○ Vertigo, dizziness ○ Blurred vision ○ Loss of hot/cold facial sensation ○ None
Which of your symptoms was the worst?	○ Generalized weakness ○ Muscular pain ○ Joint pain ○ Chest pain ○ Shortness of breath ○ Difficulty breathing ○ Chills ○ Fever ○ Feverishness ○ Nasal congestion ○ Runny nose ○ Sneezing ○ Sore throat ○ Cough ○ Sputum production ○ Loss of appetite ○ Nausea ○ Vomiting ○ Diarrhea (liquid stools) ○ Headache ○ Conjunctivitis (eye infection) ○ Skin rash/lesion or redness ○ Change or loss of smell ○ Change or loss of taste ○ Vertigo, dizziness ○ Blurred vision ○ Loss of hot/cold facial sensation ○ None

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ANNEX 1 – SENSORY PERCEPTION	
Baseline information	
Before the onset of COVID-19 related symptoms, how do you evaluate your capacity to smell odours?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply
Before the onset of COVID-19 related symptoms, how do you evaluate your capacity to taste foods in general?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply
Have you had any of the following?	
Brain surgery	○ No ○ Yes
Nose surgery (ex: fracture, rhinoplasty)	○ No ○ Yes
Sinus surgery (ex: polyps, abscess drainage)	○ No ○ Yes
Radiation therapy (head)	○ No ○ Yes
Did the surgery or radiation therapy impact your ability to smell odours?	○ No ○ Yes ○ Does not apply

QUESTIONS RELATING TO THE 72 HOURS BEFORE AND 72 HOURS AFTER THE DIAGNOSTIC OF COVID-19 *Record the worse	
Sense of smell – Note the worse during this period	
Did the change or loss of smell occur…	○ Suddenly (from one day to the next) ○ Progressively (over several days) ○ Does not apply
If there is a change in smell, is it…	○ Light ○ Moderate ○ Severe
How do you evaluate your capacity to recognize the smell scented odors (perfume, soap, shampoo, flowers, etc.)?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply
How do you evaluate your capacity to recognize the smell of smoke (wood fire, burnt toast, cigarettes)?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply
How do you evaluate your capacity to recognize the smell garbage or compost?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply

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How do you evaluate your capacity to recognize the smell of freshly poured coffee?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply
Sense of taste – Note the worse during this period	
Did you experience a change in taste?	○ No ○ Yes
Did you experience a loss of taste?	○ No ○ Yes
Did the change or loss of taste occur…	○ Suddenly (from one day to the next) ○ Progressively (over several days) ○ Does not apply
If there is a change in taste, is it…	○ Light ○ Moderate ○ Severe
How do you evaluate your capacity to taste foods?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply
How do you evaluate your capacity to taste salt?	○ Not at all ○ Weak ○ Good ○ Very good ○ Don't know/Does not apply

Before ending this call, do you have any questions?

Thank you for taking the time to answer our research questions regarding COVID-19. We wish a good day.

IF THERE ARE OTHER MEMBERS OF YOUR FAMILY THAT BEEN TESTED FOR COVID-19 AND ARE ADULTS OVER 18 YEARS OF AGE, WE WOULD LIKE TO SPEAK TO THEM PLEASE. WHAT IS THEIR NAME?

NOTES

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