RECOVER
Researching COVID to Enhance Recovery

An Initiative Funded by the National Institutes of Health

Long COVID Symptom Tracker

Use this tracker to document your symptoms. Sharing your Long COVID experiences with your doctor can help them focus on the specific answers and care you need.

Name: _____

Today's Date: _____ **Date of Confirmed COVID-19** (if known)**:** _____

My 3 most burdensome symptoms:

1. _____
2. _____
3. _____

HOW TO USE THIS TRACKER

1. **Track your symptoms and rate the impact of your symptoms**. Document which specific symptoms you're experiencing, and how they're affecting you, using the "Daily Symptom and Severity Tracker" on pages 2 - 4. From 0 (no impact) to 10 (worst imaginable), indicate how much your symptoms are affecting each body system during the week.
2. **Note your activities and triggers.** Use the "Daily Activities & Symptom Triggers" section on page 5 to help your doctor spot patterns, like whether a "crash" follows a specific activity by 24–48 hours.
3. **Note other factors.** Log any life circumstances that may affect your health and your care under the "Long COVID Social Factors" section on page 5.
4. **Bring this tracker to your next medical appointment**. Share this information with your doctor or healthcare team.

***Disclaimer**: RECOVER Representatives developed this material. The opinions expressed herein are their own. This material should not be interpreted as representing the official viewpoint of the U.S. Department of Health and Human Services (HHS) or the National Institutes of Health (NIH) or ascribing future directions for the federal government or agencies thereof.*

DAILY SYMPTOM AND SEVERITY TRACKER

This daily log is designed to help you capture the "ebb and flow" of Long COVID symptoms. Tracking symptoms daily can help you and your care team identify patterns. Throughout the week, **check the box for the day(s)** when symptoms occur and **rate your daily energy level**. At the end of the week, **rate the severity of your symptoms** across the different body systems **and your overall energy level for the week.** Add notes about your symptoms as needed.

Week of: _____

BODY SYSTEM	SYMPTOM	M	TU	W	TH	F	SA	SU	OVERALL SEVERITY
1 Neurological & Sleep	Brain fog								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Daytime drowsiness								
	Headaches								
	Insomnia								
	Memory loss								
	Migraines								
	Numbness								
	Pins, needles, and nerve pain (peripheral neuropathy)								
	Shakiness of hands, legs, head, and voice (tremors)								
2 Cardiovascular (Heart & Lungs)	Chest pain								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Chest tightness								
	Dizziness on standing								
	Fast heartbeat (tachycardia)								
	Fatigue								
	Feeling faint								
	High blood pressure								
	Long-lasting cold hands/feet								
	Palpitations								
	Racing heart rate								
	Shortness of breath (dyspnea)								
	Swelling of legs/feet (edema)								
3 Respiratory (Lungs)	Persistent cough								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Shortness of breath (dyspnea)								
	Tight chest								
	Wheezing								

BODY SYSTEM	SYMPTOM	M	TU	W	TH	F	SA	SU	OVERALL SEVERITY
4 Endocrine & Metabolic	Drastic changes in blood panel test results								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Extreme thirst								
	Frequent urination								
	Night sweats								
	Weight changes								
5 Kidney & Gastrointestinal	Abdominal bloating								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Abnormal urine								
	Blood in urine (hematuria)								
	Constipation/diarrhea								
	Stomach pain								
	Swollen gums (gum inflammation)								
6 Immune System	Hives/rashes								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Joint swelling								
	New allergies								
	Sensitive to medication/food								
7 Sensory	Balance challenges/loss								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Blurred vision								
	Dizziness								
	Eye pain								
	Light sensitivity								
	Loss of hearing								
	Loss of smell/taste (anosmia)								
	Ringing in the ears (tinnitus)								
8 Joints & Muscles	Joint pain (arthralgia)								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Muscle pain (myalgia)								
	Muscle wasting (atrophy)								
9 Skin & Hair	Burning/itching skin								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	COVID toes (swollen, discolored toes after COVID-19)								
	Hair loss								
	Rashes								
	Skin discoloration								

BODY SYSTEM	SYMPTOM	M	TU	W	TH	F	SA	SU	OVERALL SEVERITY
10 Systemic (Full Body)	**Dryness in mouth, eyes, and skin**								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Extreme fatigue (tiredness)								
	Nonrestorative sleep								
	Post-exertional malaise (PEM) (crashes)								
11 Reproductive System	**Early menopause / premature ovarian insufficiency**								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Irritability								
	Breast tenderness								
	Lower back pain								
	More severe cramping								
	Heavy menstrual bleeding								
	Absence of menstrual periods (amenorrhea)								
	Reduced reserve / fertility markers								
	Erectile dysfunction								
	Lower testosterone								
	Reduced sperm count/quality								
12 Other	**Symptom:** _____								-- / 10 *(0 = no impact; 10 = worst imaginable)*
	Symptom: _____								
	Symptom: _____								
	Symptom: _____								
	Symptom: _____								
13 Energy Level	**Rate your energy level each day on a scale of 0 to 10.** *0 = no energy* *10 = high energy*	--	--	--	--	--	--	--	-- / 10 *(0 = no energy; 10 = high energy)*

DAILY ACTIVITIES & SYMPTOM TRIGGERS

Write down your activity and **whether your symptoms got worse** afterward. If symptoms worsened, note what changed and when (e.g., "fatigue worse 6 hours after grocery shopping" or "crash the next day after a long phone call").

Physical Activity *(Exercise, household chores, working)*

Cognitive (Mental) Load *(Zoom or phone calls, reading, preparing taxes)*

Social and Emotional Stress *(Loud environment, difficult conversations)*

Food and Medication Changes *(New supplement, high-sugar meal)*

LONG COVID SOCIAL FACTORS

Life circumstances can affect your health and your care.
Check any that apply and **share your answers** with your care team so they can help connect you with support.

- ☐ Do you eat smaller meals or skip meals because you don't have money for food or water?
- ☐ Are you unhoused, or worried that you might be in the future?
- ☐ Do you have trouble paying bills?
- ☐ Do you have trouble finding or paying for transportation?
- ☐ Are you without regular income?
- ☐ Do you need daycare, or better daycare, for your kids?
- ☐ Do you feel unsafe?
- ☐ Are you physically or emotionally hurt/threatened?
- ☐ Do you feel neglected/isolated?
- ☐ In the last 6 months, have you been to the Emergency Department more than twice?
- ☐ In the last 6 months, have you been hospitalized? If so, how many times? _____

Clear Form