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

	☐ Cough ☐ Eye irritation ☐ Skin rash ☐ Pain in the chest ☐ Heart palpitation ☐ Anxiety ☐ Depression ☐ Gastrointestinal symptoms (nausea, diarrhea, stomach pain) ☐ Fatigue ☐ Dizziness ☐ No symptoms
Did you have any of these symptoms one month after your COVID-19 diagnosis? Tick one or more options.	☐ 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
Did you have any of these symptoms three months after COVID-19 diagnosis? Tick one or your more options.	☐ 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

Did you have any of these symptoms six months after your COVID-19 diagnosis? Tick one or more options.	☐ 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? Tick one or more options.	☐ 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? • *100 means that you are in the best possible health, 0 means that you are in the worst possible health.* • Tick one option.	☐ 100 ☐ 95 ☐ 90 ☐ 85 ☐ 80 ☐ 75 ☐ 70 ☐ 65 ☐ 60 ☐ 55 ☐ 50 ☐ 45 ☐ 40 ☐ 35 ☐ 30 ☐ 25 ☐ 20 ☐ 15 ☐ 10 ☐ 5 ☐ 0
How did you experience your general health before COVID-19? • *100 means that you were in the best possible health, 0 means you were in the worst possible health.* • Tick one option.	☐ 100 ☐ 95 ☐ 90 ☐ 85 ☐ 80 ☐ 75 ☐ 70 ☐ 65 ☐ 60 ☐ 55 ☐ 50 ☐ 45 ☐ 40 ☐ 35 ☐ 30 ☐ 25 ☐ 20 ☐ 15 ☐ 10 ☐ 5 ☐ 0

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? B) If "Yes," for how many weeks?	☐ Yes ☐ No ……………..
A) Were you on sick leave (with a doctor's certificate) before the pandemic (during 2019)? B) If "Yes," for how many weeks?	☐ Yes ☐ No ……….
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