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	☐ Hypertension
diagnosed by a doctor (before you fell ill	Other heart disease
with COVID-19)? Tick one or more	Diabetes mellitus (type 1 or 2)
options.	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	Better
relative to that among other people of the	Same
same age?	Worse
How would you rate your physical fitness	Better
before COVID-19 relative to that among	Same
other people of the same age?	Worse
Did you have any of these symptoms at	Fever
onset? Tick one or more options.	Breathing problems
	Muscle/joint pain
	Sore throat
	Headache
	Impaired sense of smell and taste
	Nasal congestion

	Eye irritation
	Skin rash
	Pain in the chest
	Heart palpitation
	Anxiety
	Depression
	Gastrointestinal symptoms (nausea,
	diarrhea, stomach pain)
	Fatigue
	Dizziness
D: 1 1	No symptoms
Did you have any of these symptoms one	Fever
month after your COVID-19 diagnosis?	Breathing problems
Tick one or more options.	Muscle/joint pain
	Sore throat
	Headache
	Impaired sense of smell and taste
	☐ Nasal congestion
	Eye irritation
	Skin rash
	Pain in the chest
	Heart palpitation
	Anxiety
	Depressed mood
	Gastrointestinal symptoms (nausea,
	diarrhea, stomach pain)
	Fatigue
	Dizziness
D: 1 1 6 41 41	No symptoms
Did you have any of these symptoms three	Fever
months after COVID-19 diagnosis? Tick	Breathing problems
one or your more options.	Muscle/joint pain
	Sore throat
	Headache
	Impaired sense of smell and taste
	Nasal congestion
	Eye irritation
	Skin rash
	Pain in the chest
	Heart palpitation
	Anxiety
	Depressed mood
	Gastrointestinal symptoms (nausea,
	diarrhea, stomach pain)
	Fatigue
	Dizziness
	No symptoms
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months after your COVID-19 diagnosis? Tick one or more options. 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 Breathing problems Muscle/joint pain Skin rash Pain in the chest Heart palpitation Anxiety Depressed mood Gastrointestinal symptoms (nausea, diarrhea, stomach pain) Eye irritation Skin rash Pain in the chest Headache Impaired sense of smell and taste Nasal congestion Cough Eye irritation Skin rash Pain in the chest 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. • Tick one option. How did you experience your general health before COVID-19? • 100 means that you are in the worst possible health, 0 means you were in the best possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health, 0 means you were in the worst possible health 0 means you were in the worst possible health 0 means you were in the worst possible health 0 means you were in the worst possible health 0 means yo	Did you have any of these symptoms six	Fever
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means you were in the worst possible $\boxed{ 10 \boxed{5} \boxed{0} }$		
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	health. • Tick one option.	

What do you do (primary occupation)?	
Tick one option.	Unemployed/looking for a job Retired
-	Student
If you are working, what is your primary	•••••
occupation?	
Have you sought healthcare (including	Yes No
phone call to a healthcare advisor, visit to	
primary care or secondary care) due to	
persistent symptoms after COVID-19?	
A) Have you been on sick leave (with a	Yes No
doctor's certificate) due to COVID-19 or	
its consequences?	
B) If "Yes," for how many weeks?	
A) Were you on sick leave (with a doctor's	Yes No
certificate) before the pandemic (during	
2019)?	
B) If "Yes," for how many weeks?	
How would you rate your work ability at	
the moment, one year after your COVID-	$6 \boxed{7} \boxed{8} \boxed{9} \boxed{10}$
19 diagnosis? Please tick one option. Zero	
is the worst and ten is the best work ability.	
How would you rate your work ability	$\square 0 \square 1 \square 2 \square 3 \square 4 \square 5 \square 6$
before the COVID-19 infection? Please	7 8 9 10
tick one option. Zero is the worst and ten is	
the best work ability.	