

Visit nyc.gov/AfterCare or call 212-268-4319 and press 4

Keep track of your symptoms

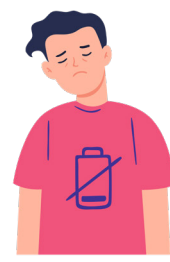


MY SYMPTOM LIST

I have symptoms that **have come back/never went away** (circle one).

My symptoms are **mild/moderate/severe** (circle one).

(For those vaccinated after they got COVID) My symptoms got **better/worse/stayed the same** (circle one) after I was vaccinated.



My ongoing symptoms are (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Dizziness on standing
(lightheadedness) |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Congestion or runny nose |
| <input type="checkbox"/> Shortness of breath or
difficulty breathing | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Tiredness or fatigue | <input type="checkbox"/> Changes in menstruation
(period cycles) |
| <input type="checkbox"/> Post-exertional malaise
(worsening of symptoms
following even minor physical or
mental exertion) | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Muscle or joint aches/weakness | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Headache | <input type="checkbox"/> New confusion or brain fog |
| <input type="checkbox"/> Chest or stomach pain | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Fast-beating or pounding heart
(also known as heart palpitations) | <input type="checkbox"/> Anxiety or depression |
| <input type="checkbox"/> Change in taste or smell | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Pins-and-needles feeling | <input type="checkbox"/> Difficulty waking up/staying awake |
| | <input type="checkbox"/> Pale/gray/blue skin/lips/nail beds |
| | <input type="checkbox"/> Other: |
