Supplementary Table 1. Enrollment Criteria

Enrollment Criteria for COVID-19 recovered patients for the Follow-up Visit	
Inclusion Criteria	
1	Patients recovered from Omicron infection discharged from Huashan Hospital after March 20 (including patients recovered from asymptomatic, mild, and severe or critical COVID-19): 1) Positive for SARS-CoV-2 nucleic acid test 2) Definition of different severity degrees of COVID-19: The asymptomatic type has mild clinical symptoms, and no pneumonia manifestation can be found in imaging. The mild type shows the symptoms above and pneumonia manifestation can be seen in imaging. The severe type (fulfill any one of the criteria follows): (1) shortness of breath, respiratory rate (RR) more than or equal to 30/min. (2) oxygen saturation ≤ 93% in the resting state. (3) arterial partial pressure of oxygen (PaO2) / fraction of inspired oxygen (FiO2) ≤ 300 mmHg. (4) clinical symptoms aggravated, and pulmonary imaging showed that the lesions progressed more than 50% within 24-48 hours.
2	Age >18 years old
Exclusion Criteria	
1	Refuse to participate in this study
2	Unable to complete necessary questionnaires
3	Individuals with unknown COVID-19 vaccination history or lack of the clinical information of COVID-19 infection
Enrollment Criteria for Healthy Participants	
Inclusion Criteria	
1	No clinical or laboratory confirmed history of SARS-CoV-2 infection.
2	Age >18 years old
Exclusion Criteria	
1	Refuse to participate in this study
2	Unable to complete necessary questionnaires
3	Individuals with unknown COVID-19 vaccination history or lack of the clinical information of COVID-19 infection

Supplementary Table 2. Symptom Questionnaire for COVID-19 Survivors

1. Have you experienced fatigue now?

□ No (go Q2) □ Yes (go Q1.1)

1.1 Is it newly onset post COVID-19?

□ No (go Q1.2) □ Yes (go Q2)

1.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

2. Have you experienced muscle weakness now?

□ No (go Q3) □ Yes (go Q2.1)

2.1 Is it newly onset post COVID-19?

□ No (go Q2.2) □ Yes (go Q3)

2.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

3. Have you experienced sleep difficulty now?

□ No (go Q4) □ Yes (go Q3.1)

3.1 Is it newly onset post COVID-19?

□ No (go Q3.2) □ Yes (go Q4)

3.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

4. Have you experienced hair loss now?

□ No (go Q5) □ Yes (go Q4.1)

4.1 Is it newly onset post COVID-19?

□ No (go Q4.2) □ Yes (go Q5)

4.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

5. Have you experienced smell disorder now?

□ No (go Q6) □ Yes (go Q5.1)

5.1 Is it newly onset post COVID-19?

□ No (go Q5.2) □ Yes (go Q6)

5.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

6. Have you experienced palpitations now?

□ No (go Q7) □ Yes (go Q6.1)

6.1 Is it newly onset post COVID-19?

□ No (go Q6.2) □ Yes (go Q7)

6.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

7. Have you experienced decreased appetite now?

□ No (go Q8) □ Yes (go Q7.1)

7.1 Is it newly onset post COVID-19?

□ No (go Q7.2) □ Yes (go Q8)

7.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

8. Have you experienced taste disorder now?

□ No (go Q9) □ Yes (go Q8.1)

8.1 Is it newly onset post COVID-19?

□ No (go Q8.2) □ Yes (go Q9)

8.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

9. Have you experienced dizziness now?

□ No (go Q10) □ Yes (go Q9.1)

9.1 Is it newly onset post COVID-19?

□ No (go Q9.2) □ Yes (go Q10)

9.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

10. Have you experienced nausea or vomiting now?

□ No (go Q11) □ Yes (go Q10.1)

10.1 Is it newly onset post COVID-19?

□ No (go Q10.2) □ Yes (go Q11)

10.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

11. Have you experienced chest pain now?

□ No (go Q12) □ Yes (go Q11.1)

11.1 Is it newly onset post COVID-19?

□ No (go Q11.2) □ Yes (go Q12)

11.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

12. Have you experienced sore throat or difficult to swallow now?

□ No (go Q13) □ Yes (go Q12.1)

12.1 Is it newly onset post COVID-19?

□ No (go Q12.2) □ Yes (go Q13)

12.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

13. Have you experienced difficult to swallow now?

□ No (go Q14) □ Yes (go Q13.1)

13.1 Is it newly onset post COVID-19?

□ No (go Q13.2) □ Yes (go Q14)

13.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

14. Have you experienced skin rash now?

□ No (go Q15) □ Yes (go Q14.1)

14.1 Is it newly onset post COVID-19?

□ No (go Q14.2) □ Yes (go Q15)

14.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

15. Have you experienced myalgia now?

□ No (go Q16) □ Yes (go Q15.1)

15.1 Is it newly onset post COVID-19?

□ No (go Q15.2) □ Yes (go Q16)

15.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

16. Have you experienced headache now?

□ No (go Q17) □ Yes (go Q16.1)

16.1 Is it newly onset post COVID-19?

□ No (go Q16.2) □ Yes (go Q17)

16.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

17. Have you experienced cough now?

□ No (go Q18) □ Yes (go Q17.1)

17.1 Is it newly onset post COVID-19?

□ No (go Q17.2) □ Yes (go Q18)

17.2 Is it worse than the status prior to COVID-19?

□ No □ Yes

18. Have you experienced joint pain now?

□ No □ Yes (fill in the table below)

If other joints, please specify___________

Joints	Hand	Foot	Wrist	Ankle	Jaw	Elbow	Shoulder	Neck	Hip	Knee
Tenderness										
Swollen										
Pain scale (0-10)										
Newly onset post COVID-19 (if no, please fill in the next line)	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes
Worse than status prior COVID-19	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes	□ No □ Yes

0 (no pain) ⟶ 10 (Intolerable pain)

19. Other symptoms needed to be recorded_____________.

Supplementary Table 3. Symptom Questionnaire for Healthy Control

Have you recently experienced any of the following symptoms that last for more than two months?

1 □ Fatigue
2 □ Muscle weakness
3 □ Sleep difficulty
4 □ Hair loss
5 □ Smell disorder
6 □ Palpitations
7 □ Decreased appetite
8 □ Taste disorder
9 □ Dizziness
10 □ Nausea or vomiting
11 □ Chest pain
12 □ Sore throat or difficult to swallow
13 □ Difficult to swallow
14 □ Skin rash
15 □ Myalgia
16 □ Headache
17 □ Cough
18 □ Joint pain

If other joints, please specify___________

Joints	Hand	Foot	Wrist	Ankle	Jaw	Elbow	Shoulder	Neck	Hip	Knee
Tenderness										
Swollen										
Pain scale (0-10)										

0 (no pain) ⟶ 10 (Intolerable pain)

19. Other symptoms needed to be recorded_____________.

Supplementary Table 4. The modified British Medical Research Council (mMRC) Dyspnea Scale

Description	Grade
I only get breathless with strenuous exercise	0
I get short of breath when hurrying on level ground or walking up a slight hill	1
On level ground, I walk slower than people of my age because of breathlessness, or I have to stop for breath when walking at my own pace on the level	2
I stop for breath after walking about 100 yards or after a few minutes on level ground	3
I am too breathless to leave the house or I am breathless when dressing/undressing	4

Supplementary Table 5. The EuroQol Five-Dimension Five-Level (EQ-5D-5L) Questionnaire

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY	
I have no problems in walking about	☐
I have slight problems in walking about	☐
I have moderate problems in walking about	☐
I have severe problems in walking about	☐
I have severe problems in walking about	☐
SELF-CARE	
I have no problems washing or dressing myself	☐
I have slight problems washing or dressing myself	☐
I have moderate problems washing or dressing myself	☐
I have severe problems washing or dressing myself	☐
I am unable to wash or dress myself	☐
USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)	
I have no problems doing my usual activities	☐
I have slight problems doing my usual activities	☐
I have moderate problems doing my usual activities	☐
I have severe problems doing my usual activities	☐
I am unable to do my usual activities	☐
PAIN / DISCOMFORT	
I have no pain or discomfort	☐
I have slight pain or discomfort	☐
I have moderate pain or discomfort	☐
I have severe pain or discomfort	☐
I have extreme pain or discomfort	☐
ANXIETY / DEPRESSION	
I am not anxious or depressed	☐
I am slightly anxious or depressed	☐
I am moderately anxious or depressed	☐
I am severely anxious or depressed	☐
I am extremely anxious or depressed	☐

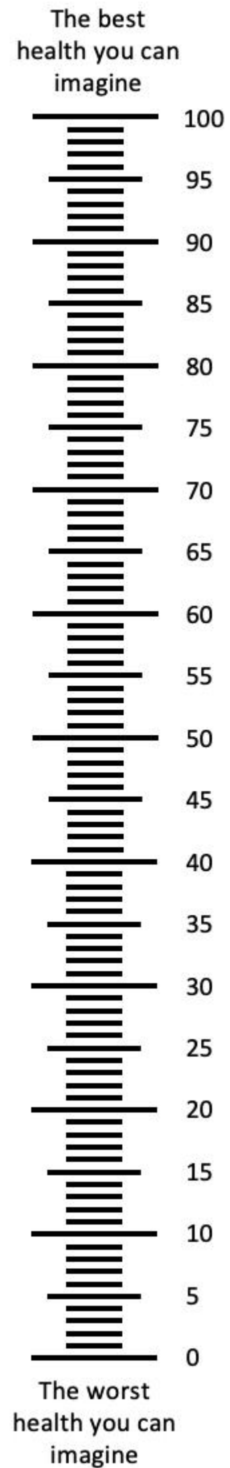
Supplementary Table 6. Generalized Anxiety Disorder-7 (GAD-7) Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Question	Response
Feeling nervous, anxious or on edge?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Not being able to stop or control worrying?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Worrying too much about different things?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Trouble relaxing?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Being so restless that it is hard to sit still?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Becoming easily annoyed or irritable?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Feeling afraid as if something awful might happen?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day

Supplementary Table 7. the EuroQol Visual Analogue Scale (EQ-VAS)

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.



YOUR HEALTH TODAY = ☐

Notes:

- There should be only ONE response for each dimension
- Missing values are preferably coded as '9'.
- Ambiguous values (e.g. two boxes are ticked for a single dimension) should be treated as missing values.
- This example is for the EQ-5D-5L Paper Self-Complete. Instructions for the interview and proxy versions are provided with those instruments.

Supplementary Table 8. The Patients Health Questionnaire (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Feeling down, depressed, or hopeless?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Trouble falling or staying asleep, or sleeping too much?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Feeling tired or having little energy?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Poor appetite or overeating?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way?	☐ Not at all
	☐ Several days
	☐ More than half the days
	☐ Nearly every day
Total =	
Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.	

Supplementary Table 9. PTSD CheckList – Civilian Version (PCL-C)

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2.	Repeated, disturbing dreams of a stressful experience from the past?					
3.	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful experience from the past?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
6.	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7.	Avoid activities or situations because they remind you of a stressful experience from the past?					
8.	Trouble remembering important parts of a stressful experience from the past?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being “super alert” or watchful on guard?					
17.	Feeling jumpy or easily startled?					