Additional file 1: Questionnaire

Front-line medical staff questionnaire on symptoms of COVID-19 (The first round)

Dear Sir/Madam:

This is a questionnaire on COVID-19 typical symptom. The aim is to generate a comprehensive list of typical symptoms of inpatient with COVID-19, which can be used to assess the disease burden caused by the symptoms. This study will adopt the method of disability adjusted life years (DALYs) of the World Health Organization (WHO) to evaluate inpatients' burden of disease caused by COVID-19 symptoms.

According to your clinical experience, please judge the raw list of category and symptoms summarized by the literature review (Table 1). The judgment items are included:

For category：

(1) Whether the category should be included in the list;

(2) Whether the name of the category is appropriate.

For symptoms：

(1) Whether the symptom should be listed;

(2) Whether the symptom should be classified into the current category;

(3) Whether the name of the symptom is appropriate.

If you think it is necessary, please supplement the symptom list according to your clinical experience. You can add:

(1) New categories if necessary;

(2) New symptoms if necessary.

As a front-line clinical expert engaged in COVID-19 treatment, your knowledge about the symptoms of the disease is valuable. Therefore, your opinion is very important for this study. Please try your best to fill the list appropriately. All the information you fill in is for academic research only. We will not analyze your responses individually and will keep them anonymous. Please provide responses to the best of your knowledge.

According to the Delphi process, the opinions of each expert in this round will be anonymously submitted to other experts as reference, in the next round of questionnaire survey. You will also see the anonymous opinions of the other experts. This study is expected to be conducted in 2-3 rounds for a more consistent answer.

Thank you for your support and cooperation.

The Research Group on COVID-19 Burden of Disease

Date**:** _____

Table1: COVID-19 inpatient's symptom list for the burden of disease evaluation (Template)

Category (Code)	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Symptom	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Should it be moved to another category? If yes, type the code
Systemic symptoms (01)				Fever				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Neurological symptoms (02)				Headache				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Respiratory symptoms (03)				Expiratory dyspnea				
				Cough				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Cardiovascular symptoms (04)				Palpitations				
				Other symptom 1 (if necessary):				

Category (Code)	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Symptom	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Should it be moved to another category? If yes, type the code
				Other symptom 2 (if necessary):				
Gastrointestinal symptoms (05)				Diarrhea				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Other category (06) (if necessary):				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Other category (07) (if necessary):				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				

If you have anything else to explain, please write here:

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To confirm the above, please sign (or type here)：_____

Date：_____

Front-line medical staff questionnaire on symptoms of COVID-19 (The second/third round)

Dear Sir/Madam:

Thank you for your cooperation and hard work in the last round of the questionnaire survey. The anonymous opinions of other experts in the last round have been sent to you as a reference. We retained all the consensus items in the last round of the expert consultation in the list. We also added the most favorite (approval rate > 50%) new items or the items that were proposed for adjustment (Table 1). Please supplement with the necessary items according to your own clinical experience and the opinions of other experts.

According to your clinical experience, please judge the newly added or adjusted category and symptom items:

For category：

(1) Whether the category should be included in the list;

(2) Whether the name of the category is appropriate.

For symptom：

(1) Whether the symptom should be listed;

(2) Whether the symptom should be classified into the current category;

(3) Whether the name of the symptom is appropriate.

Besides, you also can add:

(1) New categories if necessary;

(2) New symptoms if necessary.

According to the Delphi process, the opinion of each expert in this round will be anonymous and submitted to other experts as reference, in the next round of the questionnaire survey. You will also see the anonymous opinions of the other experts. This study is expected to be conducted in 2-3 rounds for a more consistent answer.

Thank you for your support and cooperation.

The Research Group on COVID-19 Burden of Disease

Date：_____

Table1: COVID-19 inpatient's symptom list for the burden of disease evaluation (Template)

Category (Code)	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Symptom	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Should it be moved to another category? If yes, type the code
Systemic symptoms (01)				Fever and fatigue [*]				
				Muscular soreness [*]				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Neurological symptoms (02)				Headache				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Respiratory symptoms (03)				Expiratory dyspnea				
				Cough				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Cardiovascular symptoms (04)				Palpitations				
				Chest tightness [*]				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				

Category (Code)	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Symptom	Include the item or not (Y/N)	Term appropriate or not (Y/N)	If inappropriate, fill in alternative terms	Should it be moved to another category? If yes, type the code
Gastrointestinal symptoms (05)				Diarrhea				
				Vomiting [*]				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Psychological symptoms [*] (06)				Anxiety and depression [*]				
				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				
Other category (07) (if necessary):				Other symptom 1 (if necessary):				
				Other symptom 2 (if necessary):				

* Newly proposed or adjusted item.

If you have anything else to explain, please write here:

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To confirm the above, please sign (or type here)：_____

Date：_____