

QUESTIONNAIRES (English)

Code

Socioeconomic factors	
Age years	Sex <input type="checkbox"/> Male <input type="checkbox"/> female
Township	
Education	
<input type="checkbox"/> Illiterate	<input type="checkbox"/> Middle school education level
<input type="checkbox"/> Read and write	<input type="checkbox"/> High school education level
<input type="checkbox"/> Primary school education level	<input type="checkbox"/> Graduate and above
Occupation	
<input type="checkbox"/> Dependent	
<input type="checkbox"/> Unskilled laborer	
<input type="checkbox"/> Own business	
<input type="checkbox"/> Private employee	
<input type="checkbox"/> Government staff	
Marital status	
<input type="checkbox"/> Single	
<input type="checkbox"/> Married	
<input type="checkbox"/> Separate	
<input type="checkbox"/> Divorced	
<input type="checkbox"/> Widowed	
Living situation	
<input type="checkbox"/> Alone	
<input type="checkbox"/> With family	
<input type="checkbox"/> With friends	
<input type="checkbox"/> Others, please specify	
Household size	Monthly family income kyats
Smoking status	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol drinking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comorbidity	<input type="checkbox"/> Yes <input type="checkbox"/> No

Epidemic-related factors		
Contact history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infected to family members	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Travelling history to abroad	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Travelling history to townships under stay at home order	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Presenting symptom	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological factors		
Psychological history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological history in family members	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychosocial supports		
Social support	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental support	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Depressive symptoms in patients with COVID-19

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

Statements	During the past week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1 I was bothered by things that usually don't bother me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I did not feel like eating; m appetite was poor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I felt that I could not shake off the blues even with help from my family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 I felt I was just as good as other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I had trouble keeping my mind on what I am doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I felt depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I thought my life had been a failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 My sleep was restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 I was happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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|----|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 13 | I talked less than usual. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 | I felt lonely. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 | People were unfriendly. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 | I enjoyed life. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 | I had crying spells. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 | I felt sad. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 | I felt people dislike me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 | I could not get “going”. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |