PATIENT QUESTIONNAIRE

Study Number ☐☐☐☐☐☐☐

Patient Initials ☐☐☐☐

Date of Birth (mmyyyy) ☒☒/☐☐/☐☐☐☐

Date completed (ddmmyyyy) ☐☐/☐☐/☐☐☐☐

PLEASE ANSWER THE QUESTIONS AS TO HOW YOU'VE BEEN FEELING OVER THE LAST 2 WEEKS BY TICKING THE BOX NEXT TO THE APPROPRIATE ANSWER

Have you had any pain in your lower tummy recently?

- ☐ 0 = None
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always

If Yes, how severe is the pain?

- ☐ 1 = Minimal
- ☐ 2 = Tolerable
- ☐ 3 = Intense
- ☐ 4 = Excruciating

Does pain in your lower tummy interfere with daily activities?

- ☐ 0 = No
- ☐ 3 = Yes

Are you taking any medication for this pain?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, please give name of medication & how often you take this

_____

_____

Have you had any recent vaginal bleeding?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how often?

- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

Have you had any hot flushes recently?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how do you rate these?

- ☐ 1 = Mild
- ☐ 2 = Moderate
- ☐ 3 = Interfering with everyday life

PLEASE TICK THE APPROPRIATE BOX

How often have you had hot flushes?

- ☐ 1 = Less than weekly
- ☐ 2 = Weekly or more
- ☐ 3 = Every day/ night

Are you taking Hormone Replacement Therapy?

- ☐ 0 = No
- ☐ 1 = Yes

The next section refers to your bowels

Please state if you have had any operations or treatment relating to your bowels and when this took place

_____

_____

Do you get any pain when you open your bowels?

- ☐ 0 = No
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always

If Yes, how severe is this pain?

- ☐ 1 = Minimal
- ☐ 2 = Tolerable
- ☐ 3 = Intense
- ☐ 4 = Excruciating

When you feel a desire to open your bowels do you need to go straight away?

- ☐ 0 = No
- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

How often have you felt the desire to open your bowels urgently and were unable to?

- ☐ 0 = Never
- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

Have you had any diarrhoea recently?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how many times do you have diarrhoea each day?

_____

PLEASE TICK THE APPROPRIATE BOX

If Yes, how has it changed since your radiotherapy?

- ☐ 1 = Increase of less than 4 times a day
- ☐ 2 = Increase of 4 – 6 times a day
- ☐ 3 = 7 or more times a day/ incontinence
- ☐ 8 = I have not had radiotherapy treatment yet.

Do you have any difficulty in controlling your bowels? (e.g. any accidents)

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how often?

- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

If Yes, do you require?

- ☐ 0 = No pads
- ☐ 1 = Occasional pads
- ☐ 2 = Daily use of pads

Does difficulty in controlling your bowels interfere with daily activities?

- ☐ 0 = No
- ☐ 3 = Yes

Are you taking any tablets for diarrhoea?

- ☐ 0 = No
- ☐ 1 = Yes

If yes, please give name

_____

How often do you take these in any one week?

- ☐ 1 = Less than 2 tablets per week
- ☐ 2 = 2 or more tablets per week

Have you had any bleeding recently when you've opened your bowels?

- ☐ 0 = No
- ☐ 2 = Yes

If Yes, how often have you noticed this?

_____

If Yes, did you need any treatment for this?

- ☐ 0 = No
- ☐ 1 = Yes

If yes, what treatment did you require?

_____

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Have you recently suffered with constipation?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how often do you open your bowels?

- ☐ 0 = More than 4 times per week
- ☐ 1 = 3-4 per week
- ☐ 2 = 2 per week
- ☐ 3 = Only 1 per week
- ☐ 4 = Less than this

Are you taking any medication for this?

- ☐ 0 = No
- ☐ 1 = Yes

If yes, please give name

_____

If Yes, how often

- ☐ 0 = None
- ☐ 1 = Occasionally
- ☐ 2 = Regularly

Does constipation affect your daily activities?

- ☐ 0 = No
- ☐ 3 = Yes

Have you passed any black motions recently?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how often have you noticed this?

- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

Please could you state your weight (kg)

_____

Have you passed any sticky/ slimy motions recently?

- ☐ 0 = No
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always

Please give the names of any other medication you are taking for your bowels and how often you take this

_____

_____

PLEASE TICK THE APPROPRIATE BOX

The next section refers to your bladder

Please state if you have had any operations or treatment relating to your bladder and when this took place

_____

Are you getting any pain on passing urine?

- ☐ 0 = None
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always

If Yes, how severe is this pain?

- ☐ 1 = Minimal
- ☐ 2 = Tolerable requires analgesics, not affecting activities
- ☐ 3 = Intense interferes with ADL, interferes with activities
- ☐ 4 = Excruciating

When you feel a desire to pass urine do you need to go straight away

- ☐ 0 = No
- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

Have you had any blood in your urine recently?

- ☐ 0 = No
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often with clot
- ☐ 4 = Always

How frequently do you pass urine?

- ☐ 0 = Less than every 4 hours
- ☐ 1 = Once every 3-4 hours
- ☐ 2 = Once every 2-3 hours
- ☐ 3 = Once every 1-2 hours
- ☐ 4 = Every hour

How do you rate this?

- ☐ 0 = Normal
- ☐ 1 = Up to 2 x normal
- ☐ 2 = Over 2 x normal
- ☐ 3 = Once every 1 hour or more

Do you have to get up during the night to pass urine?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, please state how many times?

- ☐ 0 = 0 - 1
- ☐ 1 = 2 - 3
- ☐ 2 = 4 - 6
- ☐ 3 = 7 or more

PLEASE TICK THE APPROPRIATE BOX

Do you suffer with incontinence of urine?

- ☐ 0 = None
- ☐ 1 = Less than every week
- ☐ 2 = Less than every day
- ☐ 3 = Several times a day
- ☐ 4 = All the time

Are you incontinent of urine when you cough or sneeze?

- ☐ 0 = No
- ☐ 1 = Yes

Do you need to use of pads for incontinence?

- ☐ 0 = No
- ☐ 2 = Yes

Is the incontinence interfering with normal daily activity?

- ☐ 0 = No
- ☐ 3 = Yes

Is your flow of urine weaker now than before Radiotherapy treatment?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 8 = I have not had radiotherapy treatment yet

If Yes, how is this affecting you?

- ☐ 1 = Hesitancy or dribbling of urine
- ☐ 2 = Requiring medication/ catheter
- ☐ 3 = Daily catheterisation required

Are you taking any medication for your bladder?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, please state the name of your medication & how often you take this

_____

_____

The next section is about your sexual function and sexual satisfaction and although the following questions are very personal, your answers will be treated in strict confidence and will remain anonymous.

Do you suffer with vaginal dryness?

- ☐ 0 = No
- ☐ 1 = Yes

If yes, how often?

- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily
- ☐ 4 = Constantly

If yes, is it?

- ☐ 1 = Mild
- ☐ 2 = Interfering with intercourse/ causing pain on intercourse

PLEASE TICK THE APPROPRIATE BOX

Are you using a cream for vaginal dryness?

- ☐ 0 = No
- ☐ 2 = Yes

If yes, please state name

_____

Do you have any vaginal discharge?

- ☐ 0 = No
- ☐ 1 = Mild
- ☐ 2 = Moderate/ heavy & pads needed

Are you getting any pain from the vagina?

- ☐ 0 = No
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always

If Yes, how severe is this pain?

- ☐ 1 = Minimal
- ☐ 2 = Tolerable
- ☐ 3 = Intense
- ☐ 4 = Excruciating

Are you taking any painkillers for this pain?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, what are your painkillers called & how often do you take these?

_____

_____

Are you currently using a dilator?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes, how often are you using this?

- ☐ 1 = Monthly
- ☐ 2 = Weekly
- ☐ 3 = Daily

Are you experiencing pain with intercourse?

- ☐ 0 = No
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always
- ☐ 8 = Not sexually active
- ☐ 9 = Don’t want to answer

If yes, is it?

- ☐ 1 = Mild
- ☐ 2 = Affecting sexual activity
- ☐ 3 = Stopping sexual activity
- ☐ 9 = Don’t want to answer

PLEASE TICK THE APPROPRIATE BOX

To what extent have you been interested in sex recently?

- ☐ 0 = The same as before treatment
- ☐ 1 = Decreased but not affecting relationship
- ☐ 2 = Decreased but is affecting relationship
- ☐ 9 = Don't want to answer

At present how does your frequency of intercourse compare to what is usual for you?

- ☐ 0 = Same as usual
- ☐ 1 = Less than usual
- ☐ 2 = Much less than usual
- ☐ 8 = Not sexually active
- ☐ 9 = Don't want to answer

Do you find this a problem?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 9 = Don't want to answer

Do you get satisfaction?

- ☐ 0 = Always
- ☐ 1 = Sometimes
- ☐ 2 = Decrease
- ☐ 3 = It is never satisfying
- ☐ 8 = Not sexually active
- ☐ 9 = Don't want to answer

Has your sex life changed since your treatment?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 8 = I have not had radiotherapy treatment yet
- ☐ 9 = Don't want to answer

Are you having any treatment for this?

- ☐ 0 = No
- ☐ 1 = Yes

Do you wish any of these symptoms to be brought to the attention of your doctor?

☐ **0 = No** ☐ **1 = Yes**

Many thanks for completing this questionnaire.