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

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

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_____

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

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

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?

- ☐ 1 = Use occasional pads
- ☐ 2 = Use pads daily
- ☐ 3 = Find it interferes with your daily activities

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

- ☐ 0 = No
- ☐ 1 = Yes

If yes, how often have you noticed this?

_____

If yes, did you need any treatment for this?

- ☐ 0 = No
- ☐ 1 = Yes

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

PLEASE TICK THE APPROPRIATE BOX

Are you taking medication for this?

- ☐ 0 = No
- ☐ 1 = Yes

If yes, please give name

_____

How often do you take the medication?

- ☐ 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

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_____

PLEASE TICK THE APPROPRIATE BOX

The next section refers to your bladder

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

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_____

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 painkillers not interfering with activities
- ☐ 3 = Intense, requires painkillers and is interfering 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 = Normal
- ☐ 1 = Up to 2x normal
- ☐ 2 = Over 2 times normal
- ☐ 3 = Once every 1hour 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

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

PLEASE TICK THE APPROPRIATE BOX

Are you incontinent of urine when you cough or sneeze?
- ☐ 0 = No
- ☐ 1 = Yes

Do you need to use pads for incontinence?
- ☐ 0 = No
- ☐ 2 = Yes

Is incontinence interfering with normal daily activity?
- ☐ 0 = No
- ☐ 3 = Yes

Is your flow of urine weaker now than before radiotherapy / brachytherapy?
- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 8 = I have not had radiotherapy/ brachytherapy treatment yet

If yes, how is it 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

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Are you getting any tiredness and headaches together?
- ☐ 0 = No
- ☐ 1 = Yes

Are you passing less urine now than you usually do?
- ☐ 0 = No
- ☐ 1 = Yes

Are your ankles swollen?
- ☐ 0 = No
- ☐ 1 = Yes

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 have difficulty having erections?
- ☐ 0 = No
- ☐ 1 = Rarely
- ☐ 2 = Sometimes
- ☐ 3 = Often
- ☐ 4 = Always
- ☐ 9 = Do not wish to answer

PLEASE TICK THE APPROPRIATE BOX

To what extent have you been interested in sex recently?

- ☐ 0 = Always
- ☐ 1 = Often
- ☐ 2 = Sometimes
- ☐ 3 = Rarely
- ☐ 4 = Never
- ☐ 9 = Do not wish to answer

Has your interest in sex altered since your treatment?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 8 = I have not had radiotherapy treatment yet
- ☐ 9 = Do not wish to answer

Are you less interested in sex now than before your treatment?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 9 = Do not wish to answer

If yes, has it affected your relationship?

- ☐ 1 = No
- ☐ 2 = Yes
- ☐ 9 = Do not wish 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 = Often
- ☐ 2 = Sometimes
- ☐ 3 = Very rarely
- ☐ 4 = Never
- ☐ 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

Do you require a member of your treating team to contact you regarding any of the issues raised in these questionnaires?

☐ **0 = No** ☐ **1 = Yes**

Many thanks for completing this questionnaire.