

Pelvic Floor

Post-Treatment PROMs Questionnaire



The purpose of this questionnaire is to help measure and improve the quality of healthcare services.

Completing the questionnaire

For each question please tick or write clearly inside the box that is closest to your views using a black or blue pen. Don't worry if you make a mistake; simply cross out the mistake and put a tick / write in the correct box.

IMPORTANT INFORMATION

The purpose of this questionnaire is to collect information about the quality of healthcare services. The information collected will be used to produce statistics about the quality of healthcare services offered by different healthcare providers (hospitals) across the NHS. These statistics will be used to measure and improve the quality of healthcare services.

With your permission, the personal details that you provide and other information held about you in other NHS databases will be used to analyse and interpret the information collected.

By completing this questionnaire, you are giving your consent for the information provided to be used for the purposes set out above. You are agreeing that:

- Your personal details and other relevant health information related to this operation will be held and used by the Health and Social Care Information Centre, including relevant information held about you by the National Joint Registry, the Personal Demographics Service, the Demographics Batch Service, the Secondary Uses Service and other NHS databases.
- Your personal details can be used to send you related follow-up questionnaires in the future.
- Your personal details and health information can be held and used by contractors, working on behalf of the Health and Social Care Information Centre and Department of Health for this project.

Your personal information will be handled securely and it will be anonymised after analysis and before any publication. The Health and Social Care Information Centre, the Department of Health and contractor(s) working on their behalf will not release your personal information unless required by law or where there is a clear overriding public interest. They will hold your personal information for no longer than 24 months for checking the accuracy of the information.

Your personal information may be shared with healthcare professionals involved in your care. If you do not wish for your information to be shared with healthcare professionals involved in your care please tick the box below.

☐ I do **not** want the information I give here to be shared with healthcare professionals involved in my care.

Your participation is voluntary. If you do not want to take part, do not fill in the questionnaire. You may withdraw the information you give the NHS in this questionnaire upon request, up to the point at which data are analysed and personal details removed.

Demographics and Surgical Detail

Patient Details

Please write your name and address in CAPITAL LETTERS.

First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address
Line 1:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address
Line 2:

City/Town:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

County:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Post code:

--	--	--	--	--	--	--	--

NHS No.:

--	--	--	--	--	--	--	--	--	--

Mobile No:

--	--	--	--	--	--	--	--	--	--

Email
Address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Q1. What is your date of birth?

(Please ensure this is your date of birth, **not** today's date)

		/			/					Prefer not to answer	
D	D		M	M		Y	Y	Y	Y		

Q2. Are you?

Male ☐

Female ☐

Prefer not to answer ☐

Q3. Is anyone helping you fill in this questionnaire?

Yes ☐

No ☐

Prefer not to answer ☐

If the answer is yes, please give the relationship to you of the person assisting you:

Family Member

☐

Health Care Professional

☐

Spouse

☐

Child

☐

Parent

☐

Relative

☐

Carer

☐

Neighbour

☐

Prefer not to answer

☐

Other

☐

If other, please specify:

.....

ICIQ Surgery Satisfaction

4. How would you rate the outcome of your surgery? (Tick one box)

Please add any comments you wish below

- very successful ☐ 4
somewhat successful ☐ 3
neither successful nor unsuccessful ☐ 2
little unsuccessful ☐ 1
very unsuccessful ☐ 0

5. Compared to how you felt before your surgery, how is your condition now? (Tick one box)

Please add any comments you wish below

- much better ☐ 4
a bit better ☐ 3
about the same ☐ 2
a bit worse ☐ 1
much worse ☐ 0

6. Would you say you have been able to return to a “normal” life post surgery? (Tick one box)

Please add any comments you wish below

- strongly agree (or I was not limited before) ☐ 3
agree ☐ 2
disagree ☐ 1
strongly disagree ☐ 0

7. If you were in the same situation again, would you still have the surgery? (Tick one box)

Please add any comments you wish below

- yes, definitely ☐ 4
yes, probably ☐ 3
not sure ☐ 2
no, probably not ☐ 1
no, definitely not ☐ 0

8. Would you recommend this surgery to friends or relatives with similar problems? (Tick one box)

Please add any comments you wish below

- yes, definitely ☐ 4
yes, probably ☐ 3
not sure ☐ 2
no, probably not ☐ 1
no, definitely not ☐ 0

9. If you had to spend the rest of your life with the symptoms you currently have, how would you feel? (Tick one box)

Please add any comments you wish below

- perfectly happy (or I no longer have any symptoms) ☐ 4
somewhat happy ☐ 3
mixed feelings ☐ 2
somewhat unhappy ☐ 1
very unhappy ☐ 0

10. How prepared did you feel for this surgery? (Tick one box)

Please add any comments you wish below

- completely prepared ☐ 3
somewhat prepared ☐ 2
somewhat unprepared ☐ 1
completely unprepared ☐ 0

11. How satisfied were you with any explanation of the surgery? (Tick one box)

Please add any comments you wish below

- I did not receive any information ☐ 4
very satisfied ☐ 3
quite satisfied ☐ 2
quite dissatisfied ☐ 1
very dissatisfied ☐ 0

12. After surgery, how much pain did you experience? (Tick one box)

(b) How much did this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10

not at all

a great deal

Please add any comments below

none ☐ 3

a little ☐ 2

a lot ☐ 1

severe pain ☐ 0

13. How satisfied were you with any treatment you had for pain? (Tick one box)

I did not require pain treatment ☐ 4

very satisfied ☐ 3

quite satisfied ☐ 2

quite dissatisfied ☐ 1

very dissatisfied ☐ 0

Please add any comments you wish below

14. How much pain are you experiencing now? (Tick one box)

(b) How much did this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10

not at all

a great deal

Please add any comments below

none ☐ 3

a little ☐ 2

a lot ☐ 1

severe pain ☐ 0

15. Were there any complications or side effects with your surgery? (Tick one box)

no complications ☐ 2

yes, minor complications ☐ 1

yes, major complications ☐ 0

Please add any comments you wish below

16. Overall, has the result of your surgery been...? (Tick one box)

better than you expected ☐ 3

different than expected ☐ 2

just as you expected ☐ 1

worse than you expected ☐ 0

Please add any comments you wish below

17. Overall, how satisfied were you with your surgery?

Please ring a number between 0 (not satisfied) and 10 (very satisfied)

0 1 2 3 4 5 6 7 8 9 10

not satisfied

very satisfied

Medication and Treatment Inventory

Q18. What prescription medications have you been taking regularly during the last month?

Medicine 1 _____

Medicine 2 _____

Medicine 3 _____

Medicine 4 _____

Medicine 5 _____

Please list any additional prescribed medications:

.....

.....

Q19. What prescription medications have you been taking regularly during the last month? [other medications]

.....

.....

.....

Post-Surgery Symptoms

Q20. Is there anything else you would like to share with us in relation to the operation and its impact on your health, including any symptoms you may have experienced which you attribute to your surgery and are not covered in the sections above?

.....

.....

(EQ5DL) - Under each heading, please tick the ONE box that best describes your health today:

Q21. 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 am unable to walk about

☐

Prefer not to answer

☐

Q22. 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

☐

Prefer not to answer

☐

Q23. 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

☐

Prefer not to answer

☐

Q24. 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

☐

Prefer not to answer

☐

Q25. 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

☐

Prefer not to answer

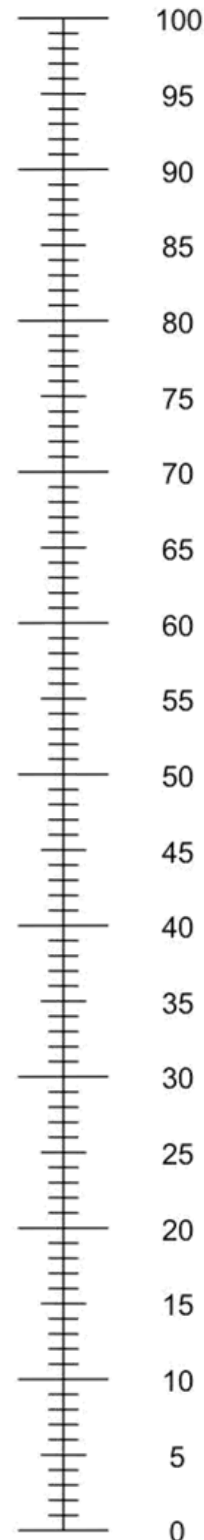
☐

Q26. Visual Analogue Scale

- 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.
- Please mark an X on the scale to indicate how your health is TODAY.
- Now, write the number you marked on the scale in the box .

YOUR HEALTH TODAY =

The best health
you can imagine



Q27. - Q31.

WHO (Five) Well Being Index

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

Please respond to each item by marking <u>one box per row</u> , regarding how you felt in the last two weeks.		All of the time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
WHO 1	I have felt cheerful in good spirits.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 2	I have felt calm and relaxed.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 3	I have felt active and vigorous.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 4	I woke up feeling fresh and rested.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 5	My daily life has been filled with things that interest me.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Scoring:

The raw score is calculated by totaling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life.

To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.

National PROMS Questions

Q32. Living Arrangements - Which statement best describes your living arrangements?

I live with a partner / spouse / family / friend

☐

I live alone

☐

I live in a nursing home, hospital or other long-term care

☐

Prefer not to answer

☐

Other

☐

If other, please specify:

.....

Q33. Please confirm when your Pelvic Floor operation took place?

☐☐

D D

/

☐☐

M M

/

☐☐☐☐

Y Y Y Y

Q34. Did you experience any of the following problems after your operation? Please tick the box or boxes that apply?

Allergy or Reaction to Drug

☐

Urinary Problems

☐

Bleeding

☐

Wound Problems

☐

Prefer not to answer

☐

Q35. In general, would you say your health is: (Please Tick One):

Excellent

☐

Very Good

☐

Good

☐

Fair

☐

Poor

☐

Prefer not to answer

☐

Q36. Questionnaire completion date?

(This is today's date)

D D

/

M M

/

Y Y Y Y

Q37. Do you consider yourself to have a disability?

Yes ☐

No ☐

Prefer not to answer ☐

For Office Use Only

Thank you for your help

Please return this questionnaire to the person who gave it to you

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