



## F512: Cost and Utilities Questionnaire

### F512: Cost and Utilities Questionnaire, version 09/08/08 (A)

#### SECTION A: GENERAL STUDY INFORMATION FOR OFFICE USE ONLY

A1. Study ID#:

LABEL

A2. Visit # Baseline.....VBAS  
F/U 12 Months.....V12M

A3. Date Form Distributed: \_\_\_/\_\_\_/\_\_\_  
Month Day Year

A4. Study Staff Initials: \_\_\_\_\_

A5. Mode: Self-Administered..... 1  
Interviewer-Administered..... 2

A6. Which version of this form was used? English .....1  
Spanish.....2

A7. Is this a repeat measure? Yes ..... 1  
No..... 2

**Introduction:** This questionnaire includes questions about costs in your daily life that are related to your problem of incontinence.

As with all of the information we collect for the ValUE study, all of your responses are completely confidential. Your responses are never linked with your name, and your name never appears on any of the research documents. Providing this information will not affect any of your services, benefits, or eligibility for coverage.

**The Cost and Utilities Questionnaire takes about 15 minutes to complete. Ideally, you will be able to complete it in one sitting.**

There are two (2) parts included in this questionnaire. Please read the instructions at the start of each section carefully. Try to answer every item, but do not dwell too long on any one question. We want your answers, so please try to complete the survey on your own. After you have completed the survey, please check to make sure you have not missed any items. If you have any questions about any of these items, please call me.

\_\_\_\_\_ at \_\_\_\_\_  
 Contact Name Phone number

**A8. What is the date that you are starting to fill out this survey?** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year

**SECTION B: EXPENSES FOR SUPPLIES, LAUNDERING AND DRY CLEANING**

**NUMBER OF SUPPLIES USED**

Over the past 7 days, please record the average number of supplies you used each day for your urinary incontinence.

**B1. Pantyliners or minipads (Check one box only)**

- |                            |   |                             |              |
|----------------------------|---|-----------------------------|--------------|
| <input type="checkbox"/> 0 | None ( <i>I did not use this product in the last 7 days</i> ) | <input type="checkbox"/> 6  | 6            |
| <input type="checkbox"/> 1 | 1   | <input type="checkbox"/> 7  | 7            |
| <input type="checkbox"/> 2 | 2   | <input type="checkbox"/> 8  | 8            |
| <input type="checkbox"/> 3 | 3   | <input type="checkbox"/> 9  | 9            |
| <input type="checkbox"/> 4 | 4   | <input type="checkbox"/> 10 | 10           |
| <input type="checkbox"/> 5 | 5   | <input type="checkbox"/> 11 | more than 10 |

**B2. Maxipads such as Kotex or Modess (Check one box only)**

- |                            |   |                             |              |
|----------------------------|---|-----------------------------|--------------|
| <input type="checkbox"/> 0 | None ( <i>I did not use this product in the last 7 days</i> ) | <input type="checkbox"/> 6  | 6            |
| <input type="checkbox"/> 1 | 1   | <input type="checkbox"/> 7  | 7            |
| <input type="checkbox"/> 2 | 2   | <input type="checkbox"/> 8  | 8            |
| <input type="checkbox"/> 3 | 3   | <input type="checkbox"/> 9  | 9            |
| <input type="checkbox"/> 4 | 4   | <input type="checkbox"/> 10 | 10           |
| <input type="checkbox"/> 5 | 5   | <input type="checkbox"/> 11 | more than 10 |

**B3. Incontinence Pads such as Serenity or Poise (Check one box only)**

- |                            |   |                             |              |
|----------------------------|---|-----------------------------|--------------|
| <input type="checkbox"/> 0 | None ( <i>I did not use this product in the last 7 days</i> ) | <input type="checkbox"/> 6  | 6            |
| <input type="checkbox"/> 1 | 1   | <input type="checkbox"/> 7  | 7            |
| <input type="checkbox"/> 2 | 2   | <input type="checkbox"/> 8  | 8            |
| <input type="checkbox"/> 3 | 3   | <input type="checkbox"/> 9  | 9            |
| <input type="checkbox"/> 4 | 4   | <input type="checkbox"/> 10 | 10           |
| <input type="checkbox"/> 5 | 5   | <input type="checkbox"/> 11 | more than 10 |

**B4. Diapers such as Depends or Attends (Check one box only)**

- |                            |   |                             |              |
|----------------------------|---|-----------------------------|--------------|
| <input type="checkbox"/> 0 | None ( <i>I did not use this product in the last 7 days</i> ) | <input type="checkbox"/> 6  | 6            |
| <input type="checkbox"/> 1 | 1   | <input type="checkbox"/> 7  | 7            |
| <input type="checkbox"/> 2 | 2   | <input type="checkbox"/> 8  | 8            |
| <input type="checkbox"/> 3 | 3   | <input type="checkbox"/> 9  | 9            |
| <input type="checkbox"/> 4 | 4   | <input type="checkbox"/> 10 | 10           |
| <input type="checkbox"/> 5 | 5   | <input type="checkbox"/> 11 | more than 10 |

**B5. Urethral pads such as Impress, Femassist (Check one box only)**

- None (*I did not use this product in the last 7 days*)
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11 more than 10

**B6. Toilet paper - number of sheets (Check one box only)**

- None (*I did not use this product in the last 7 days*)
- 1 to 10
- 11 to 20
- 21 to 30
- 31 to 40
- 41 to 50
- 51 to 60
- 61 to 70
- 71 to 80
- 81 to 90
- 91 to 100
- more than 100

**B7. Paper towels - number of sheets (Check one box only)**

- None (*I did not use this product in the last 7 days*)
- 1 to 10
- 11 to 20
- 21 to 30
- 31 to 40
- 41 to 50
- 51 to 60
- 61 to 70
- 71 to 80
- 81 to 90
- 91 to 100
- more than 100

**B8. Other (Please describe what you used: \_\_\_\_\_)**

- None (*I did not use any other product in the last 7 days*)
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11 more than 10

**CHANGING AND WASHING CLOTHING AND LINENS**

**B9. How many loads of wash did you do during the last 7 days because of your incontinence?**

(Check one box only)

- None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- more than 7

**DRY CLEANING**

How many items of clothing did you dry clean during the last 7 days *because of your incontinence*?

**B10. Pants***(Check one box only)*

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 6 6             |
| <input type="checkbox"/> 1 1    | <input type="checkbox"/> 7 7             |
| <input type="checkbox"/> 2 2    | <input type="checkbox"/> 8 8             |
| <input type="checkbox"/> 3 3    | <input type="checkbox"/> 9 9             |
| <input type="checkbox"/> 4 4    | <input type="checkbox"/> 10 10           |
| <input type="checkbox"/> 5 5    | <input type="checkbox"/> 11 more than 10 |

**B11. Skirt***(Check one box only)*

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 6 6             |
| <input type="checkbox"/> 1 1    | <input type="checkbox"/> 7 7             |
| <input type="checkbox"/> 2 2    | <input type="checkbox"/> 8 8             |
| <input type="checkbox"/> 3 3    | <input type="checkbox"/> 9 9             |
| <input type="checkbox"/> 4 4    | <input type="checkbox"/> 10 10           |
| <input type="checkbox"/> 5 5    | <input type="checkbox"/> 11 more than 10 |

**B12. Dress***(Check one box only)*

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 6 6             |
| <input type="checkbox"/> 1 1    | <input type="checkbox"/> 7 7             |
| <input type="checkbox"/> 2 2    | <input type="checkbox"/> 8 8             |
| <input type="checkbox"/> 3 3    | <input type="checkbox"/> 9 9             |
| <input type="checkbox"/> 4 4    | <input type="checkbox"/> 10 10           |
| <input type="checkbox"/> 5 5    | <input type="checkbox"/> 11 more than 10 |

**B13. Suit***(Check one box only)*

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 6 6             |
| <input type="checkbox"/> 1 1    | <input type="checkbox"/> 7 7             |
| <input type="checkbox"/> 2 2    | <input type="checkbox"/> 8 8             |
| <input type="checkbox"/> 3 3    | <input type="checkbox"/> 9 9             |
| <input type="checkbox"/> 4 4    | <input type="checkbox"/> 10 10           |
| <input type="checkbox"/> 5 5    | <input type="checkbox"/> 11 more than 10 |

**B14. Blouse***(Check one box only)*

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 6 6             |
| <input type="checkbox"/> 1 1    | <input type="checkbox"/> 7 7             |
| <input type="checkbox"/> 2 2    | <input type="checkbox"/> 8 8             |
| <input type="checkbox"/> 3 3    | <input type="checkbox"/> 9 9             |
| <input type="checkbox"/> 4 4    | <input type="checkbox"/> 10 10           |
| <input type="checkbox"/> 5 5    | <input type="checkbox"/> 11 more than 10 |

**LOSS OF EMPLOYMENT AND VOLUNTEER WORK**

**B15. Did your urinary incontinence limit your years of employment or volunteer work?**

- Yes ↓                       No → **SKIP TO SECTION C**

**B15a. If yes, how old were you when you stopped your employment or volunteer work DUE to incontinence?**

\_\_\_\_\_ years old

**B15b. How much additional money per month would you have earned if you had continued your work?**

\$ \_\_\_\_\_ . \_\_\_\_\_

**SECTION C: MATTERS OF HEALTH: THE HEALTH UTILITIES INDEX (HUI)**

**Instructions:** This next section contains questions which ask about various aspects of your health. When answering these questions please think about your health and your ability to do things on a day-to-day basis, during the past week. To define the past week period, please think about the date this time 7 days ago and recall the major events that you have experienced during this period. Please focus your answers on your overall abilities, disabilities and how you felt during the past week.

You may feel that some of these questions do not apply to you, but it is important that we ask the same questions of everyone. Also, a few questions are similar; please excuse the apparent overlap and answer each question independently.

Please read each question and consider your answers carefully. For each question, please select one answer that best describes your level of ability or disability during the past week. Please indicate the selected answer by circling the number beside the answer.

All information you provide is confidential. There are no right or wrong answers; what we want is your opinion about your abilities and feelings.

C1. Which one of the following best describes your ability, during the past week, to see well enough to read ordinary newsprint?

- Able to see well enough without glasses or contact lenses. .... 1
- Able to see well enough with glasses or contact lenses ..... 2
- Unable to see well enough even with glasses or contact lenses. .... 3
- Unable to see at all..... 4

C2. Which one of the following best describes your ability, during the past week, to see well enough to recognize a friend on the other side of the street?

- Able to see well enough without glasses or contact lenses ..... 1
- Able to see well enough with glasses or contact lenses ..... 2
- Unable to see well enough even with glasses or contact lenses. .... 3
- Unable to see at all..... 4

C3. Which one of the following best describes your ability, during the past week, to hear what was said in a group conversation with at least three other people?

- Able to hear what was said without a hearing aid. .... 1
- Able to hear what was said with a hearing aid ..... 2
- Unable to hear what was said even with a hearing aid. .... 3
- Unable to hear what was said, but did not wear a hearing aid ..... 4
- Unable to hear at all..... 5

C4. Which one of the following best describes your ability, during the past week, to hear what was said in a conversation with one other person in a quiet room?

- Able to hear what was said without a hearing aid. .... 1
- Able to hear what was said with a hearing aid ..... 2
- Unable to hear what was said even with a hearing aid. .... 3
- Unable to hear what was said, but did not wear a hearing aid ..... 4
- Unable to hear at all..... 5

C5. Which one of the following best describes your ability, during the past week, to be understood, when speaking your own language with people who do not know you?

- Able to be understood completely ..... 1
- Able to be understood partially ..... 2
- Unable to be understood..... 3
- Unable to speak at all..... 4

C6. Which one of following best describes your ability, during the past week to be understood when speaking with people who know you well?

- Able to be understood completely ..... 1
- Able to be understood partially ..... 2
- Unable to be understood ..... 3
- Unable to speak at all..... 4

C7. Which one of the following best describes how you have been feeling during the past week?

- Happy and interested in life..... 1
- Somewhat happy..... 2
- Somewhat unhappy..... 3
- Very unhappy. .... 4
- So unhappy that life was not worthwhile ..... 5

C8. Which one of the following best describes the pain and discomfort you have experienced during the past week?

- Free of pain and discomfort..... 1
- Mild to moderate pain or discomfort that prevented no activities..... 2
- Moderate pain or discomfort that prevented a few activities ..... 3
- Moderate to severe pain or discomfort that prevented some activities ..... 4
- Severe pain or discomfort that prevented most activities..... 5



C9. Which one of the following best describes your ability, during the past week, to walk?  
Note: Walking equipment refers to mechanical supports such as braces, a cane, crutches or a walker.

- Able to walk around the neighborhood without difficulty, and without walking equipment ..... 1
- Able to walk around the neighborhood with difficulty; but did not require walking equipment or the help of another person ..... 2
- Able to walk around the neighborhood with walking equipment, but without the help of another person ..... 3
- Able to walk only short distances with walking equipment, and required a wheelchair to get around the neighborhood..... 4
- Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and required a wheelchair to get around the neighborhood..... 5
- Unable to walk at all..... 6

C10. Which one of the following best describes your ability, during the past week, to use your hands and fingers?

Note: Special tools refers to hooks for buttoning clothes, gripping devices for opening jars or lifting small items, and other devices to compensate for limitations of hands or fingers.

- Full use of two hands and ten fingers ..... 1
- Limitations in the use of hands or fingers, but did not require special tools or the help of another person..... 2
- Limitations in the use of hands or fingers, independent with use of special tools (did not require the help of another person)..... 3
- Limitations in the use of hands or fingers, required the help of another person for some tasks (not independent even with use of special tools)..... 4
- Limitations in the use of hands or fingers, required the help of another person for most tasks (not independent even with use of special tools)..... 5
- Limitations in the use of hands or fingers, required the help of another person for all tasks (not independent even with use of special tools) ..... 6

C11. Which one of the following best describes your ability, during the past week, to remember things?

- Able to remember most things..... 1
- Somewhat forgetful ..... 2
- Very forgetful ..... 3
- Unable to remember anything at all ..... 4

C12. Which one of the following best describes your ability, during the past week, to think and solve day to day problems?

- Able to think clearly and solve day to day problems ..... 1
- Had a little difficulty when trying to think and solve day to day problems ..... 2
- Had some difficulty when trying to think and solve day to day problems ..... 3
- Had great difficulty when trying to think and solve day to day problems ..... 4
- Unable to think or solve day to day problems ..... 5

C13. Which one of the following best describes your ability, during the past week, to perform basic activities?

- Eat, bathe, dress and use the toilet normally ..... 1
- Eat, bathe, dress or use the toilet independently with difficulty..... 2
- Required mechanical equipment to eat, bathe, dress or use the toilet independently ..... 3
- Required the help of another person to eat, bathe, dress or use the toilet ..... 4

C14. Which one of the following best describes how you have been feeling during the past week?

- Generally happy and free from worry ..... 1
- Occasionally fretful, angry, irritable, anxious or depressed. .... 2
- Often fretful, angry, irritable, anxious or depressed..... 3
- Almost always fretful, angry, irritable, anxious or depressed... .. 4
- Extremely fretful, angry, irritable, anxious or depressed;  
to the point of needing professional help..... 5

C15. Which one of the following best describes the pain or discomfort you have experienced during the past week?

- Free of pain and discomfort..... 1
- Occasional pain or discomfort. Discomfort relieved by non-prescription drugs or self-control activity without disruption of normal activities ..... 2
- Frequent pain or discomfort. Discomfort relieved by oral medicines with occasional disruption of normal activities ..... 3
- Frequent pain or discomfort; frequent disruption of normal activities. Discomfort required prescription narcotics for relief ..... 4
- Severe pain or discomfort. Pain not relieved by drugs and constantly disrupted normal activities ..... 5

C16. Overall, how would you rate your health during the past week?

- Excellent..... 1
- Very good..... 2
- Good..... 3
- Fair ..... 4
- Poor..... 5

C17. How did you complete the questionnaire? Please select the one answer that best describes your situation?

- By myself, without any help from anyone else..... 1     ➔ **END OF FORM**
- By myself, except someone else circled the answers on the questionnaire form for me. .... 2     ➔ **END OF FORM**
- With the help of someone else. .... 3     ➔ **END OF FORM**
- This questionnaire was completed by a family member, without help from the subject or patient.... 4

C17a. If this questionnaire was completed without help from the subject or patient, who completed it?

- Nurse or Other Health Professional .... 1     ↓ **SPECIFY TYPE OF HEALTH PROFESSIONAL**  
\_\_\_\_\_
- Other Person..... 2     ↓ **SPECIFY RELATIONSHIP TO PATIENT**  
\_\_\_\_\_

**YOU ARE DONE WITH THIS SURVEY. THANK YOU.**