F548: Follow-Up Patient Survey

F548: Follow-Up Patient Survey, Version 10/21/09 (B)

SECTION A: GENERAL STUDY INFORMATION FOR OFFICE USE ONLY

A1. Study ID #: LABEL

A2. Visit # F/U 3 Months V03M

F/U 12 Months V12M

A3. Date Form Distributed: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

A4. Study Staff Initials: ____ ____ ____

A5. Mode: Self-Administered 1

With assistance (family member/friend) 3

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

Spanish 2

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Introduction: The survey contains questions about your current urinary symptoms, quality of life, capabilities to perform routine daily living activities and satisfaction with treatment.

As with all of the information we collect for this research 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.

This survey should take about 15 minutes to complete. Ideally, you will be able to complete the entire survey in one sitting.

There are four (4) parts to the Follow-Up Patient Survey. Please read the instructions at the start of each section carefully before you begin each new section.

Try to answer every item, but do not dwell too long on any one question. We want your answers, so please complete the questionnaire 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 ________________________________.

A7. Date you are completing this survey? ____ ____ / ____ ____ / ____ ____ ____ ____
Month **Day** **Year**

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SECTION B: MESA and PGI-S

This first set of questions asks about symptoms you may currently have related to urine leakage. For each question, please circle the **ONE** response that best represents how frequently you currently experience the symptom.

MESA PART I		**Never**	**Rarely**	**Sometimes**	**Often**
B1.	Does coughing gently cause you to lose urine?	0	1	2	3
B2.	Does coughing hard cause you to lose urine?	0	1	2	3
B3.	Does sneezing cause you to lose urine?	0	1	2	3
B4.	Does lifting things cause you to lose urine?	0	1	2	3
B5.	Does bending cause you to lose urine?	0	1	2	3
B6.	Does laughing cause you to lose urine?	0	1	2	3
B7.	Does walking briskly or jogging cause you to lose urine?	0	1	2	3
B8.	Does straining, if you are constipated, cause you to lose urine?	0	1	2	3
B9.	Does getting up from a sitting to a standing position cause you to lose urine?	0	1	2	3

MESA PART II		**Never**	**Rarely**	**Sometimes**	**Often**
B10.	Some women receive very little warning and suddenly find that they are losing, or are about to lose urine beyond their control. How often does this happen to you?	0	1	2	3
B11.	If you can’t find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?	0	1	2	3
B12.	Do you lose urine when you suddenly have the feeling that your bladder is very full?	0	1	2	3
B13.	Does washing your hands cause you to lose urine?	0	1	2	3
B14.	Does cold weather cause you to lose urine?	0	1	2	3
B15.	Does drinking cold beverages cause you to lose urine?	0	1	2	3

PGI-S		**Normal**	**Mild**	**Moderate**	**Severe**
B16.	Circle the **one** number that best describes how your urinary tract condition is now.	1	2	3	4

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SECTION C: QUALITY OF LIFE - PART I

These questions deal specifically with your accidental urine loss and/or prolapse. The symptoms in this section have been described by women who experience accidental urine loss and/or prolapse. Please indicate which symptoms you are now experiencing, and how bothersome they are for you. Be sure to circle an answer for all items.

GENERAL INSTRUCTIONS: Please read the first column of symptoms and circle "Yes" or "No" for each symptom. Then, for each question marked by a **"Yes"** answer, work across the page and tell us how bothersome that symptom is for you currently.

Do you currently experience any of the following symptoms?			**IF YES,** Circle the one response below that best describes how bothersome that symptom is for you.			
	Yes	**No**	**Not at all Bothersome**	**Slightly Bothersome**	**Moderately Bothersome**	**Greatly Bothersome**
C1. …frequent urination?	1	2	0	1	2	3
C2. …a strong feeling of urgency to empty your bladder?	1	2	0	1	2	3
C3. …urine leakage related to the feeling of urgency?	1	2	0	1	2	3
C4. …urine leakage related to physical activity, coughing or sneezing?	1	2	0	1	2	3
C5. ...general urine leakage **not** related to urgency or activity?	1	2	0	1	2	3
C6. …small amounts of urine leakage (that is, drops)?	1	2	0	1	2	3
C7. …large amounts of urine leakage?	1	2	0	1	2	3
C8. …nighttime urination?	1	2	0	1	2	3
C9. …bedwetting?	1	2	0	1	2	3
C10. …difficulty emptying your bladder?	1	2	0	1	2	3

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Do you currently experience any of the following symptoms?			IF YES, circle the one response below that best describes how bothersome that symptom is for you.			
	Yes	**No**	**Not at All Bothersome**	**Slightly Bothersome**	**Moderately Bothersome**	**Greatly Bothersome**
C11. …a feeling of incomplete bladder emptying?	1	2	0	1	2	3
C12. …lower abdominal pressure?	1	2	0	1	2	3
C13. …pain when urinating?	1	2	0	1	2	3
C14. …pain in the lower abdominal or genital area?	1	2	0	1	2	3
C15. …heaviness or dullness in the pelvic area?	1	2	0	1	2	3
C16. …a feeling of bulging or protrusion in the vaginal area?	1	2	0	1	2	3
C17. ...bulging or protrusion you can see in the vaginal area?	1	2	0	1	2	3
C18. ...pelvic discomfort when standing or physically exerting yourself?	1	2	0	1	2	3
C19. Do you have to push on the vagina or perineum to empty your bladder?	1	2	0	1	2	3
C20. Do you have to push on the vagina or perineum to have a bowel movement?	1	2	0	1	2	3

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C21. Do you experience any **other** symptoms related to accidental urine loss or prolapse?

Yes 1

No .... 2 ➔ **SKIP TO C22**

C21a. If yes, what is it (are they)? ______________________________

C22. Please go back and review all of the symptoms in Section C above, items C1 – 21, and write below the one symptom that bothers you the most. For this item, please list **one** symptom only.

____

____

C23. How often do you experience urinary leakage?

Not at all... 0 ➔ **SKIP TO C25**

Less than once a month.................... 1

A few times a month 2

A few times a week 3

Every day and/or night 4

C24. How much urine do you lose each time?

Drops 1

Small splashes 2

More 3

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Some women find that accidental urine loss and/or prolapse may affect their activities, relationships, and feelings. The questions in this section refer to areas in your life which may have been influenced or changed by your problem. For each question in this section, circle the one response that best describes how much your activities, relationships and feelings are being affected by urine leakage and/or prolapse.

To what extent has accidental urine loss and/or prolapse affected your …..

	Not at All	Slightly	Moderately	Greatly
C25. …ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
C26. …physical recreational activities such as walking, swimming, or other exercise?	0	1	2	3
C27. …entertainment activities such as going to a movie or concert?	0	1	2	3
C28. …ability to travel by car or bus for distances less than 20 minutes away from home?	0	1	2	3
C29. …participation in social activities outside your home?	0	1	2	3
C30. …emotional health?	0	1	2	3

C31. In addition, does your problem with accidental urine loss and/or prolapse cause you to experience frustration?	0	1	2	3

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SECTION D: QUALITY OF LIFE - PART II

This section asks for your views about your health. This information will help us keep track of how you feel and how well you are able to do your usual activities. These questions are about your health now and your current activities.

	Excellent	Very Good	Good	Fair	Poor
D1. In general, would you say your health is:	1	2	3	4	5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **Circle one number for each activity.**

	Yes, I'm limited a lot	Yes, I'm limited a little	No, I'm not limited at all
D2. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
D3. Climbing **several** flights of stairs	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **Circle one number for each activity**.

	Yes	No
D4. **Accomplished less** than you would like	1	2
D5. Were limited in the **kind** of work or other activities	1	2

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During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? **Circle one number for each activity**.

	Yes	No
D6. **Accomplished less** than you would like	1	2
D7. Didn't do work or other activities as **carefully** as usual	1	2

	Not at All	Slightly	Moderately	Quite a Bit	Extremely
D8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	1	2	3	4	5

These questions ask about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. **Circle one number for each activity**.

How much of the time during the past 4 weeks…

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
D9. …have you felt calm and peaceful?	1	2	3	4	5	6
D10. …did you have a lot of energy?	1	2	3	4	5	6
D11. …have you felt downhearted and blue?	1	2	3	4	5	6

	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
D12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	1	2	3	4	5

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SECTION E: SATISFACTION WITH TREATMENT RESULTS

You have had treatment to reduce urinary incontinence (urine leakage) and to lessen the impact of these symptoms on your life. These questions ask you to tell us how satisfied you are with the result(s) of your incontinence treatment related to your symptoms. This information will help us to understand your views of your treatment experience.

GENERAL INSTRUCTIONS: Please read the question and symptoms in the first column. Then, work across the page and tell us about how satisfied or dissatisfied you are with the result of your incontinence treatment related to that symptom. Circle the one response that **best** describes your level of satisfaction. If you **NEVER** experienced the symptom (neither before nor after treatment), **DO NOT** rate your satisfaction. **Instead**, circle "**NA**" in the last column labeled "**Not Applicable (NA)**".

How satisfied or dissatisfied are you with the result of incontinence treatment related to the following symptoms…

	Completely Dissatisfied	Mostly Dissatisfied	Neutral	Mostly Satisfied	Completely Satisfied	Not Applicable
E1. …Urine leakage?	1	2	3	4	5	NA
E2. …Urine leakage related to feeling of urgency?	1	2	3	4	5	NA
E3. …Urine leakage related to physical activity, coughing or sneezing?	1	2	3	4	5	NA
E4. …Frequency of urination?	1	2	3	4	5	NA

E5. Circle the **one** answer that best describes how your urinary tract condition is now, compared with how it was before your incontinence treatment:

Very much better.. 1

Much better 2

A little better 3

No change 4

A little worse.. 5

Much worse... 6

Very much worse 7

YOU ARE DONE WITH THIS SURVEY. THANK YOU.