ARISTOTLE

MALE PELVIS QUESTIONNAIRE

Trial Number A R I – | | | | **Patient Initials** | | |

Visit Date d d / m m / y y y y

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

1) Do you get any pain when you open your bowels? ☐ Yes ☐ No

A) If yes, how severe is this pain?

☐ Minimal
☐ Tolerable, requires painkillers, not interfering with activities
☐ Intense, requires painkillers, interferes with activities
☐ Excruciating, interferes with all activities

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

☐ No ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

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

☐ No ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

4) Have you had diarrhoea recently? ☐ Yes ☐ No

A) If yes, how has it changed compared to before your radiotherapy?

☐ Increase of less than 4 times a day
☐ Increase of 4-6 times a day
☐ 7 or more times a day/incontinence
☐ I cannot compare as I have only just begun my radiotherapy treatment

5) How many times do you have diarrhoea each day? | |

6) Are you taking any tablets for diarrhoea? ☐ Yes ☐ No

A) If yes, please give name: _____

7) Do you have any difficulty in controlling your bowels? (e.g. any accidents) ☐ Yes ☐ No

A) If yes, how often? ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

B) If yes do you require: ☐ No pads ☐ Occasional pads ☐ Daily use of pads

C) Does difficulty in controlling your bowels interfere with daily activities? ☐ Yes ☐ No

8) Have you had any bleeding recently when you've opened your bowels? ☐ Yes ☐ No

A) If yes, did you need any treatment for this? ☐ Yes ☐ No

B) If yes, what treatment did you require? _____

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9) Have you recently suffered with constipation? ☐ Yes ☐ No

A) If yes, are you taking any medication for this? ☐ Yes ☐ No

B) If yes, please give name: _____

C) How often do you take the medication? ☐ Occasionally ☐ Regularly

D) Does constipation affect your daily activities? ☐ Yes ☐ No

10) Have you passed any sticky/slimy motions recently?

☐ No ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

THE NEXT SECTION REFERS TO YOUR BLADDER

11) Are you getting any pain on passing urine?

☐ None ☐ Minimal ☐ Tolerable, requires painkillers, not interfering with activities

☐ Intense, requires painkillers and is interfering with activities ☐ Excruciating

12) When you feel a desire to pass urine, do you need to go straight away?

☐ No ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

13) Have you had any blood in your urine recently? ☐ Yes ☐ No

A) If yes, did you need any treatment for this? ☐ Yes ☐ No

B) If yes, what treatment did you require? _____

14) How frequently do you pass urine

☐ Normal frequency ☐ Up to 2 X normal ☐ Over 2 X normal ☐ Once every 1 hour or more

15) Do you have to get up during the night to pass urine? ☐ Yes ☐ No

A) If yes, please state how many times ☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ 7 or more

16) Do you suffer with incontinence of urine?

☐ None ☐ Less than every week ☐ Less than every day

☐ Several times a day ☐ All the time

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A) Do you need to use pads for urinary incontinence? ☐ Yes ☐ No

B) Is incontinence interfering with normal daily activity? ☐ Yes ☐ No

17) Is your flow of urine weaker now than before radiotherapy treatment?

☐ No ☐ Yes ☐ I cannot answer as I have only just begun my radiotherapy treatment

A) If yes, how is it affecting you?

☐ Hesitancy or dribbling of urine ☐ Requiring medication/catheter ☐ Daily catheterisation required

18) Are you taking any medication for your bladder? ☐ Yes ☐ No

A) If yes, please state the name of your medication and how often you take this

_____

THE NEXT SECTION IS MORE PERSONAL, YOUR ANSWERS WILL BE TREATED IN STRICT CONFIDENCE

19) Do you have difficulty having erections? ☐ Yes ☐ No

A) Are you taking any medication to help with erections? ☐ Yes ☐ No

B) If yes, please state the name of your medication _____

20) Has your treatment affected your ability to have a sexual relationship?

☐ No ☐ Yes ☐ I cannot answer as I have only just begun my radiotherapy treatment

21) Do you find this a problem? ☐ Yes ☐ No

HAVE YOU ANY OTHER SYMPTOMS THAT YOU WOULD LIKE TO MENTION?

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