ARISTOTLE

FEMALE 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) Have you had any pain in your lower tummy recently? ☐ Yes ☐ No

A) If yes, how severe is the pain?

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

2) Are you taking any medication for this pain? ☐ Yes ☐ No

A) If yes, please give name of the medication: _____

3) Have you had any hot flushes recently? ☐ Yes ☐ No

A) If yes, how do you rate these? ☐ Mild ☐ Moderate ☐ Interfering with everyday life

B) Are you taking Hormone Replacement Therapy? ☐ Yes ☐ No

THE NEXT SECTION REFERS TO YOUR BOWELS

4) 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

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

☐ No ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

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

☐ No ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

7) 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

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

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

A) If yes, please give name: _____

10) 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

11) 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? _____

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

A) If yes, how often do you open your bowels?

☐ More than 4 times per week ☐ 3-4 per week ☐ 2 per week

☐ Only 1 per week ☐ Less than this

B) Are you taking any medication for this? ☐ Yes ☐ No

C) If yes, please give name: _____

D) If yes, how often? ☐ None ☐ Occasionally ☐ Regularly

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

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

☐ No ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

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THE NEXT SECTION REFERS TO YOUR BLADDER

14) Are you getting any pain on passing urine? ☐ 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

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

☐ No ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

16) 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? _____

17) How frequently do you pass urine

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

18) 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

19) Do you suffer with incontinence of urine? ☐ Yes ☐ No

A) If yes, are you incontinent of urine when you cough or sneeze? ☐ Yes ☐ No

B) If yes, do you need to use pads for urinary incontinence? ☐ Yes ☐ No

C) If yes, is the incontinence interfering with normal daily activity? ☐ Yes ☐ No

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

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

A) If yes, how is this affecting you?

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

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

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

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THE QUESTIONS IN THE NEXT SECTION ARE MORE PERSONAL, BUT YOUR ANSWERS WILL BE TREATED IN STRICT CONFIDENCE

22) Do you have any vaginal discharge? ☐ No ☐ Mild ☐ Moderate/heavy & pads needed

23) Are you getting any pain from the vagina? ☐ 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

24) Are you taking any painkillers for this pain? ☐ Yes ☐ No

A) If yes, what are your painkillers called? _____

25) Have you had any recent vaginal bleeding? ☐ Yes ☐ No

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

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

26) Do you suffer with vaginal dryness? ☐ Yes ☐ No

A) If yes, is it? ☐ Mild ☐ Interfering with intercourse/causing pain on intercourse

B) Are you using a cream for vaginal dryness? ☐ Yes ☐ No

C) If yes, please state name: _____

27) Are you experiencing pain with intercourse? ☐ Yes ☐ No

A) If yes, is it?

☐ Mild, not affecting sexual activity
☐ Affecting sexual activity
☐ Stopping sexual activity

28) Has your treatment affected your ability to have a sexual relationship? ☐ Yes ☐ No

A) If yes, do you find this a problem? ☐ Yes ☐ No

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