

## Patient Questionnaire Booklet

### Instructions

#### For patients

Thank you for participating in PQIP. Please complete these questions in EITHER this booklet OR online via our webtool (<https://pqip.org.uk>). Your doctors or nurses can show you how to log in to the online system. Please ask them if you have any questions.

#### For the local research team

If participants choose to complete these questions in this booklet, please ensure that the answers are transferred to the webtool and store the booklet in the secure PQIP file at your hospital.

### Contents

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2 - 7	Before surgery	Core questions
8 & 9	Before surgery	EQ5D questionnaire
10	Before surgery	WHODAS 2.0 questionnaire
11 & 12	Day 1 after surgery	Bauer Patient Satisfaction Score

### Patient Details

(Patient ID sticker can be affixed)

Surname

\_\_\_\_\_

First name(s)

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

**To be completed by the hospital**

Hospital

\_\_\_\_\_

NHS number

\_\_\_\_\_

**Patient Booklet – Page 2**  
**Please complete before surgery**  
**Core Questions**



**What is your current occupation?**

(please tick **one** box from the options below)

Retired	<input type="checkbox"/>
Parent or Carer	<input type="checkbox"/>
Unemployed for health reasons	<input type="checkbox"/>
Unemployed for other reasons	<input type="checkbox"/>
Corporate managers, science and tech/ health/teaching & research/business, public service professionals	<input type="checkbox"/>
Managers/owners in agricultural services, science & tech associated professionals, health & social welfare associated professionals, protective service professionals, culture/media/sports, business & public service associated professionals, skilled trades.	<input type="checkbox"/>
Administrative/secretarial/caring/leisure/sales/customer service occupations, process/plant/machinery/transport/mobile machine operatives	<input type="checkbox"/>
Elementary trade/plant & storage related/administration & service occupations	<input type="checkbox"/>

**Please tick one box for each of the questions below:**

Over the past two weeks has pain been bad enough to interfere with your day to day activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Over the past two weeks have you felt worried or low in mood because of this pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Patient Booklet – Page 3**  
**Please complete before surgery**  
**Core Questions**



**If you are a smoker:**

**Were you asked to attend a clinic to help you quit smoking or reduce how much you smoke?**

(please tick **one** box from the options below)

Not a smoker	<input type="checkbox"/>
Not asked to attend clinic	<input type="checkbox"/>
asked to go to a one-off clinic – didn't attend	<input type="checkbox"/>
asked to go to a one-off clinic – did attend	<input type="checkbox"/>
asked to go to an intensive programme– didn't attend	<input type="checkbox"/>
asked to go to an intensive programme– did attend	<input type="checkbox"/>

**On average over the past year,** how many minutes of moderate intensity physical activity have you done each day (e.g. brisk walking, cycling, dancing or swimming, which increases your heart rate and makes you feel slightly out of breath)?

(please tick **one** box from the options below)

<b>None, and I need help with some of these activities: washing, dressing, eating, getting around the house, going to the toilet</b>	<input type="checkbox"/>
<b>None, but I can manage all the above activities myself</b>	<input type="checkbox"/>
Less than 10 minutes	<input type="checkbox"/>
10 – 20 minutes	<input type="checkbox"/>
20- 30 minutes	<input type="checkbox"/>
More than 30 minutes	<input type="checkbox"/>

**Patient Booklet – Page 4**  
**Please complete before surgery**  
**Core Questions**



**On average over the past two weeks**, how many minutes of moderate intensity physical activity have you done each day?

(please tick **one** box from the options below)

<b>None, and I need help with some of these activities: washing, dressing, eating, getting around the house, going to the toilet</b>	<input type="checkbox"/>
<b>None, but I can manage all the above activities myself</b>	<input type="checkbox"/>
Less than 10 minutes	<input type="checkbox"/>
10 – 20 minutes	<input type="checkbox"/>
20 – 30 minutes	<input type="checkbox"/>
More than 30 minutes	<input type="checkbox"/>

**Patient Booklet – Page 5**  
**Please complete before surgery**  
**Core Questions**



**What is your highest educational qualification?**

(please tick the **box or boxes** which are relevant to you from the options below)

NVQ4	<input type="checkbox"/>
NVQ5	<input type="checkbox"/>
Degree or equivalent	<input type="checkbox"/>
Higher education below degree	<input type="checkbox"/>
NVQ3	<input type="checkbox"/>
GCE A Level equivalent	<input type="checkbox"/>
NVQ2	<input type="checkbox"/>
GCE O Level or GCSE equivalent	<input type="checkbox"/>
NVQ1	<input type="checkbox"/>
CSE other grade equivalent	<input type="checkbox"/>
No qualification	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

**Patient Booklet – Page 6**  
**Please complete before surgery**  
**Core Questions**



**What is your ethnicity?**

(please tick the **box or boxes** which are relevant to you from the options below)

<b>White:</b>	
English/Welsh/Scottish/Northern Irish/British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Gypsy or Irish Traveler	<input type="checkbox"/>
Any other White background	<input type="checkbox"/>
<b>Mixed/Multiple ethnic groups:</b>	
White and Black Caribbean	<input type="checkbox"/>
White and Black African	<input type="checkbox"/>
White and Asian	<input type="checkbox"/>
Any other Mixed/Multiple ethnic background	<input type="checkbox"/>
<b>Asian/Asian British:</b>	
Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>
Any other Asian background	<input type="checkbox"/>
<b>Black/ African/Caribbean/Black British:</b>	
African	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>
Any other Black/African/Caribbean background	<input type="checkbox"/>
<b>Other ethnic group:</b>	
Arab	<input type="checkbox"/>
Any other ethnic group	<input type="checkbox"/>

**Patient Booklet – Page 7**  
**Please complete before surgery**  
**Address details**

**Please tell us about your living status.** Do you...

(please tick the **box or boxes** which are relevant to you from the options below)

Own your home outright	<input type="checkbox"/>
Own it with help of a mortgage or loan	<input type="checkbox"/>
Pay part rent and part mortgage (shared ownership)	<input type="checkbox"/>
Rent	<input type="checkbox"/>
Live there rent free (including rent free in a relative or friend's property (excluding squatting))	<input type="checkbox"/>
Squat	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

**Patient Booklet – Page 8**  
**Please complete before surgery**  
**EQ5D – Part 1**



These questions help us understand how well you are. We would like to ask you to complete this questionnaire before your operation and we will repeat this at 6 months and one year after your operation for comparison. Please tick one box from each of the 5 sections below.

Under each heading, please tick the **one** box that best describes your health TODAY.

**1. 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

**2. 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

**3. 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

**4. 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

**5. 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

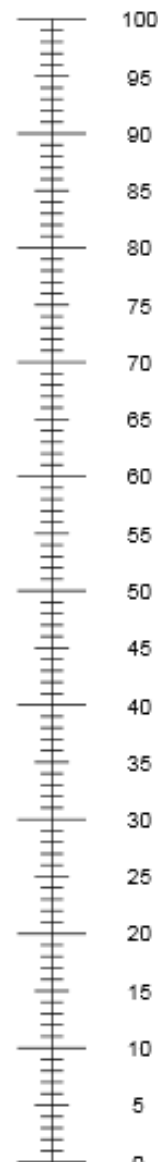


**Patient Booklet – Page 9**  
**Please complete before surgery**  
**EQ5D – Part 2**

- 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
- Mark an X on the scale to indicate how your health is TODAY
- Now, please write the number you marked on the scale in the box below

**YOUR HEALTH TODAY =**

The best health  
you can imagine



The worst health  
you can imagine

Many thanks for answering these questions – we will contact you to answer them again 6 months after your operation.

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**Patient Booklet – Page 10**  
**Please complete before surgery**  
**WHODAS 2.0**



This questionnaire asks about difficulties due to health conditions. We would like to ask you to complete this questionnaire before your operation and we will repeat this at 6 months and one year after your operation for comparison.

In the past 30 days, how much difficulty did you have in (please circle only **one** response):

S1	<u>Standing for long periods</u> such as <u>30 minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your <u>household responsibilities</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	<u>Learning a new task</u> , for example learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have <u>joining in community activities</u> in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have <u>you</u> been <u>emotionally affected</u> by your health problem?	None	Mild	Moderate	Severe	Extreme or cannot do
S6	<u>Concentrating on doing something</u> for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	<u>Walking a long distance</u> such as a kilometre (or equivalent) ?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	<u>Washing your whole body</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting <u>dressed</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	<u>Dealing with people you do not know</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	<u>Maintaining a friendship</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day <u>work</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, <u>how many days</u> were these difficulties present?	Number of days _____
H2	In the past 30 days, for how many days were you <u>totally unable</u> to carry out your usual activities or work because of any health condition?	Number of days _____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <u>cut back</u> or <u>reduce</u> your usual activities or work because of any health condition?	Number of days _____

At any stage after your operation have you had the following?  
(please tick **one** box only for each question 1-10)

**Anaesthesia-related discomfort**

		No	Yes, mild	Yes, moderate	Yes, severe
1.	Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Pain at the site of surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Feeling cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Confusion or disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Pain at the site of the anaesthetic injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Shivering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tick one box only for each question 11-16

**Satisfaction with anaesthesia care**

11.	How satisfied were you with the information you were given by the anaesthetist before the operation?			
	<input type="checkbox"/> Very satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Very dissatisfied
12.	How satisfied were you waking up from anaesthesia?			
	<input type="checkbox"/> Very satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Very dissatisfied
13.	How satisfied have you been with pain therapy after surgery?			
	<input type="checkbox"/> Very satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Very dissatisfied
14.	How satisfied were you with treatment of nausea and vomiting after the operation?			
	<input type="checkbox"/> Very satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Very dissatisfied
15.	How satisfied were you with the care provided by the department of anaesthesia in general?			
	<input type="checkbox"/> Very satisfied	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Very dissatisfied
16.	Would you recommend this anaesthetic service to friends and family?			
	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

**FOR RESEARCH TEAM**

If it was not possible for the patient to complete these questions, complete the questions on page 11