Patient Initials		Date of Birth	Day Month Year	Patient ID	Centre No	Trial No

Pain Management and Dementia

Patient Health Survey

The questions in this booklet are for the Study Researcher to ask the patient. The Study Researcher may expand or re-phrase any of the questions if they feel this would aid completion or understanding of the question **with the exception of** the health related quality of life questions which must be read as printed on the questionnaire. For the DemQol (page 10-) instructions for the ***Study Researcher*** are given below each question (in italics) to aid completion.

Please enter today's date:

d	d	m	m	y	y	y	y

Section 1: Contact with Health Services

All the questions in Section 1 refer to the **last month**. The first set of questions (questions 1-3) relate to the participant's stay in hospital whilst the second set of questions (questions 4 and 5) relate to any time in the **last month** when they were at home or not in hospital.

1. Which department(s)/ward(s) have you spent the time over the last month on? Please tick each that applies and provide the number of days you have spent in each

	General Medicine	**General Surgery**	**Orthopaedic**	**Oncology**	**High Dependency Unit**	**Intensive Care Unit**	**Other** (please specify)
Please tick each that applies							
Number of days							

2. In the **last month** whilst you have been in hospital have you had any assessments?

   please mark a cross in the appropriate box)

   Yes ☐ No ☐

If you have answered **Yes to question 2**, please could you tell us what your assessment was for or who you saw?

Medical assessment (excluding daily ward rounds):	**Please tick each assessment you have had**	**Number of times**
Surgical		
Orthopaedic		
Oncology		
Cardiology		
Respiratory		
Radiography		
CT scan		
MRI Scan		
X Ray		
Pathology		
Blood tests		
Other assessments, meetings or sessions		
Physiotherapist		
Occupational therapist		
Psychologist		
Dietitian		
Speech and language therapist		
Social worker		
Other:		

3. In the **last month** whilst you have been in hospital have you had an operation or any other procedure? (please mark a cross in the appropriate box)

   Yes ☐ No ☐

If you have answered **Yes to question 3**, please could you tell us what your operation or procedure was for? We have left space for up to four but if there are more please put the details at the end of the form

Details of operation (for example, hip replacement) of procedure (for example, laryngosophy)
I. Details:
II. Details:
III. Details:
IV. Details:

4. Over the **last month**, when you were not in hospital did you use any of the following health and social services?

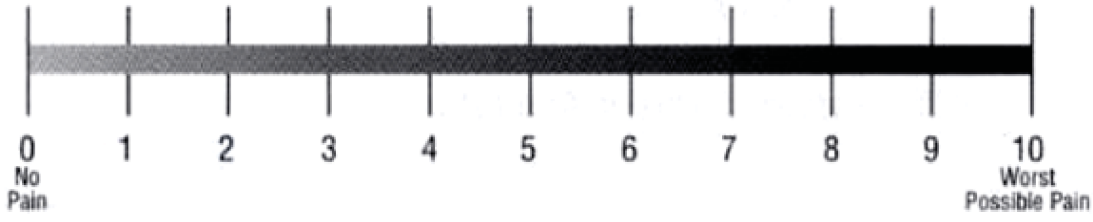
Type of service	Have you used the service during the last month? Please tick (✓) yes or no	Total number of face to face contacts during the last month	Total number of contacts by telephone or email during the last month
a. GP, surgery visit	Yes ☐ No ☐		
b. GP, home visit	Yes ☐ No ☐		
c. District nurse, health visitor or member of community health team	Yes ☐ No ☐		
d. Have you had contact with other health or social care staff such as a psychologist or home help? (please specify which type below): …… …… ……	Yes ☐ No ☐	Number contacts with each: …… …… ……	Number contacts with each: …… …… ……

5. Over the **last month**, when you were not in hospital did you use any of the following? (Please do not complete the shaded squares).

Type of service	**Which service have you used during the last month?**		**Number of days spent in hospital/ hospice in last month**	**Number of visits in last month**
Hospital day centre	Yes ☐	No ☐		
Hospital outpatient clinic	Yes ☐	No ☐		
Hospital accident and emergency	Yes ☐	No ☐		
Nursing home/ hospice stay	Yes ☐	No ☐		

Section 2: Pain Assessments

1. Please mark on the rating scale below (with an **X**) your average level of pain over the last 24 hours. Please make sure the **X** is visible



2. Are you currently taking pain medication? (please tick)

   ❑ Yes (continue with to Question 3)

   ❑ No (please go to the next section)

3. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the percentage that most shows how much relief you have received.

0% **10%** **20%** **30%** **40%** **50%** **60%** **70%** **80%** **90%** **100%**

No Relief — Complete Relief

Section 3: EQ-5D & DEMQOL

Your Health-Related Quality of Life

By placing a tick in **one** box in each group below, please indicate which statement best describes your own health state **today**.

Mobility

- I have no problems in walking about ❑
- I have some problems walking about ❑
- I am confined to bed ❑

Self Care

- I have no problems with self care ❑
- I have some problems washing or dressing myself ❑
- I am unable to wash or dress myself ❑

Usual Activities

(e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities ❑
- I have some problems with performing my usual activities ❑
- I am unable to perform my usual activities ❑

Pain/Discomfort

- I have no pain or discomfort ❑
- I have moderate pain or discomfort ❑
- I have extreme pain or discomfort ❑

Anxiety/Depression

- I am not anxious or depressed ❑
- I am moderately anxious or depressed ❑
- I am extremely anxious or depressed ❑

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.

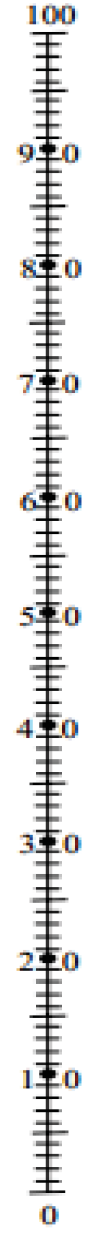
0 means the worst health you can imagine.

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