Study Number | | | | | | |

MAPS

Men After Prostate Surgery

Baseline Questionnaire

CONFIDENTIAL

MAPS TRIAL

MEN'S HEALTH AFTER PROSTATE SURGERY

Thank you for helping us with our research into urinary incontinence after prostate surgery.
We would be very grateful if you could complete and return this questionnaire.

After you have answered the questions,
we can allocate you to a treatment group.

Version 6 February 2005

Baseline Q

HOW TO FILL IN THIS QUESTIONNAIRE

Most questions can be answered by putting numbers or a tick in the appropriate box or boxes. Please print your answers carefully within the boxes like this:

2	7	OR	M	I	K	E	OR	✓

If you make a mistake, shade out the wrong box completely and tick the correct one like this

e.g. If you ticked often but meant to answer sometimes:

OFTEN	✓	**SOMETIMES**	✓	**NEVER**	

Please try to complete the whole questionnaire.

There are no right or wrong answers.

Sometimes the box you tick tells you to skip forward so that you miss out questions which do not apply to you.

In some questions we would like you to think about different time periods, such as during the last week, during the last 4 weeks or since your prostate operation. Please check the time periods carefully.

Some of the questions ask for answers in your own words, please write these in the boxes provided.

You do not have to answer any question if you do not want to.

Thank you for your help.

SECTION A – URINE SYMPTOMS

When you answer these questions, please think about how you have been in the **LAST WEEK.**

A1 **How often do you leak urine?**
*(Tick **ONE** box only)*

- Never ☐
- About once a week or less often ☐
- Two or three times a week ☐
- About once a day ☐
- Several times a day ☐
- All the time ☐

A2 **We would like to know how much urine <u>you think</u> leaks.**
How much urine do you <u>usually</u> leak (whether you wear protection or not)?
*(Tick **ONE** box only)*

- None ☐
- A small amount ☐
- A moderate amount ☐
- A large amount ☐

A3 **Overall, how much does leaking urine interfere with your everyday life?**
Please choose a number between 0 (not at all) and 10 (a great deal)
*(Tick **ONE** box only)*

Not at all	0	1	2	3	4	5	6	7	8	9	10	A great deal
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

In the following questions (**A4** to **A8**), we would like to find out when you leak urine.
When you answer these questions, please think about how you have been in the **LAST WEEK.**

A4 **Does urine leak when you cough, sneeze, or are physically active or exercising?**
*(Tick **ONE** box only)*

- Never ☐
- About once a week or less often ☐
- Two or three times a week ☐
- About once a day ☐
- Several times a day ☐
- All the time ☐

When you answer these questions, please think about how you have been in the **LAST WEEK.**

A5 **When you feel the need to urinate, do you have to rush urgently to the toilet?**
*(Tick **ONE** box only)*

- Never ☐
- About once a week or less often ☐
- Two or three times a week ☐
- About once a day ☐
- Several times a day ☐
- All the time ☐

A6 **Does urine leak when you have to rush urgently to the toilet?**
*(Tick **ONE** box only)*

- Never ☐
- About once a week or less often ☐
- Two or three times a week ☐
- About once a day ☐
- Several times a day ☐
- All the time ☐

A7 **Does urine leak when you have finished urinating and are dressed?**
*(Tick **ONE** box only)*

- Never ☐
- About once a week or less often ☐
- Two or three times a week ☐
- About once a day ☐
- Several times a day ☐
- All the time ☐

A8 **Does urine leak at times other than shown in your answers to questions A4, A6 or A7?**
*(Tick **ONE** box only)*

Yes ☐ *Go to **A8a*** No ☐ *Go to **A9***

A8a **If you do leak at other times, please give details of when you leak:**

When you answer these questions, please think about how you have been in the **LAST WEEK.**

A9 **Do you wear a pad or other protection because of leaking urine?**
*(Tick **ONE** box only)*

Yes ☐ *Go to **A9a*** No ☐ *Go to **A10***

A9a **If Yes, how many pads do you wear in an average day (24 hours)?**

Enter **TOTAL** number of pads you wear in 24 hours ☐☐

A9b **Of these pads, how many do you pay for yourself?**
If you do not pay for them, please enter zero (0) in the boxes

Enter number of pads **YOU PAY FOR** yourself ☐☐

A10 **Do you use pads or protectors on your chair or bed in case you leak urine?**
*(Tick **ONE** box only)*

Yes ☐ *Go to **A10a*** No ☐ *Go to **A11***

A10a **If Yes, how many chair or bed pads do you use in an average day (24 hours)?**

Enter **TOTAL** number of chair and bed pads you use in 24 hours ☐☐

A10b **Of these chair or bed pads, how many do you pay for yourself?**
If you do not pay for them, please enter zero (0) in the boxes

Enter number of chair and bed pads **YOU PAY FOR** yourself ☐☐

A11 **How often do you usually pass urine during the daytime?**

Enter number of times ☐☐

A12 **How often do you usually have to get up at night to pass urine?**

Enter number of times ☐☐

A13 **Are you using a permanent catheter (inside your bladder) to collect your urine?**

Yes ☐ No ☐

A14 **Do you ever use an external (sheath) catheter to collect your urine?**

Yes ☐ No ☐

SECTION B – CARE YOU HAVE RECEIVED

When you answer these questions, please think about the care you have received **SINCE YOUR PROSTATE OPERATION.**

B1 **Have you seen your family doctor (GP) since your prostate operation?**

Yes ☐ *Go to **B1a*** No ☐ *Go to **B2***

B1a **If Yes, approximately how often have you seen your family doctor (GP) since your prostate operation?**

Enter number of times seen GP **for leaking urine** ☐☐

Enter number of times seen GP **for any other reason** ☐☐

B2 **Have you seen a nurse (from your doctor's practice) since your prostate operation?**

Yes ☐ *Go to **B2a*** No ☐ *Go to **B3***

B2a **If Yes, approximately how many times have you seen a nurse from your doctor's practice since your prostate operation?**

Enter number of times seen nurse **for leaking urine** ☐☐

Enter number of times seen nurse **for any other reason** ☐☐

B3 **Since your prostate operation, have you seen NHS HOSPITAL staff <u>for leaking urine</u>?**

		If yes, enter number of visits
I have seen a hospital doctor **about leaking urine**	Yes ☐ →	Number of visits ☐☐
	No ☐	
I have seen a hospital nurse **about leaking urine**	Yes ☐ →	Number of visits ☐☐
	No ☐	
I have seen a hospital physiotherapist **about leaking urine**	Yes ☐ →	Number of visits ☐☐
	No ☐	

When you answer these questions, please think about the care you have received **SINCE YOUR PROSTATE OPERATION.**

B4 **Since your prostate operation, have you received any PRIVATE TREATMENT (which you had to pay for yourself) for leaking urine?**

If Yes, enter number of visits

I have seen a private doctor **about leaking urine**	Yes ☐	Number of visits	☐☐
	No ☐		
I have seen a private nurse **about leaking urine**	Yes ☐	Number of visits	☐☐
	No ☐		
I have seen a private physiotherapist **about leaking urine**	Yes ☐	Number of visits	☐☐
	No ☐		

B5 **Since your prostate operation, have you been admitted to hospital because of leaking urine?**

Yes ☐ *Go to **B5a*** No ☐ *Go to **B6*** ☐☐

B5a **If you were admitted since your prostate operation, how many nights did you stay in hospital?**

Enter number of nights in hospital ☐☐

B5b **Since your prostate operation, have you had an operation for leaking urine?**

Yes ☐ *Go to **B5c*** No ☐ *Go to **B6***

B5c If Yes, please give the name or type of operation and the date:

B6 **Since your prostate operation, have you taken any medications (from a doctor, or direct from the chemist's) for leaking urine?**

Yes ☐ *Go to **B6a*** No ☐ *Go to **B7***

B6a **If Yes, please give details of medication received since your prostate operation for leaking urine.**
Please give drug names (e.g. detrusitol, duloxetine):

When you answer these questions, please think about the care you have received **SINCE YOUR PROSTATE OPERATION.**

B7 **Have you had any other treatment or advice for leaking urine since your prostate operation (other than the operation you named in B5c or the drugs you listed in B6a)?**

Yes ☐ *Go to **B7a*** No ☐ *Go to **B8***

B7a **If Yes, please give details of other treatment or advice received since your prostate operation for leaking urine:**

B8 **Are you in paid employment?**

Yes ☐ *Go to **B8a*** No ☐ *Go to **Section C***

B8a **If Yes, approximately how many days off sick have you had <u>for any reason since your prostate operation</u>?**

☐☐☐ days

SECTION C – OTHER HEALTH PROBLEMS

C1 **Do you have any health or medical problems** *(such as heart, chest or kidney problems, diabetes, stroke or high blood pressure)* **<u>other than</u> those to do with your prostate operation?**

Yes ☐ No ☐

C2 **Do you take any medications** *(such as drugs or prescriptions from your doctor, or direct from the chemist's)* **<u>for these health problems</u>?**

Yes ☐ No ☐

SECTION D – BOWEL SYMPTOMS

This section is about your bowel symptoms and control of your stool (also called bowel motions or faeces). Many people experience bowel symptoms some of the time. When you answer these questions, please think about how you have been in the **LAST WEEK.**

D1 **How often do you lose control of or leak stool?**
*(Tick **ONE** box only)*

- Never ☐
- Occasionally ☐
- Sometimes ☐
- Most of the time ☐
- All of the time ☐

D2 **If you do, how much does this bother you?**
Please choose a number between 0 (not at all) and 10 (a great deal)
*(Tick **ONE** box only)*

Not at all	0	1	2	3	4	5	6	7	8	9	10	A great deal
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

D3 **When you feel the need to open your bowels, do you have to rush urgently to the toilet?**
*(Tick **ONE** box only)*

- Never ☐
- Occasionally ☐
- Sometimes ☐
- Most of the time ☐
- All of the time ☐

D4 **When you have to rush urgently, do you ever lose control of or leak stool?**
*(Tick **ONE** box only)*

- Never ☐
- Occasionally ☐
- Sometimes ☐
- Most of the time ☐
- All of the time ☐

When you answer these questions, please think about how you have been in the **LAST WEEK.**

D5 **Do you ever lose control of or leak stool WITHOUT first feeling that you have to rush urgently?**
*(Tick **ONE** box only)*

- Never ☐
- Occasionally ☐
- Sometimes ☐
- Most of the time ☐
- All of the time ☐

D6 **If stool leaks, is this usually solid, liquid or both?** *(Tick **ONE** box only)*

- Doesn't leak ☐
- Liquid only ☐
- Solid only ☐
- Liquid and solid ☐

D7 **Are you currently receiving ANY treatment or advice for leaking stool?**

Yes ☐ *Go to **D7a*** No ☐ *Go to **D8***

D7a **If Yes, please give details of treatment or advice received for leaking stool:**

D8 **Did you ever lose control of or leak stool BEFORE your prostate surgery?**

Yes ☐ No ☐

D9 **Do you have any of these other bowel problems?**
*(Tick **ALL** boxes that apply to you)*

- Ulcerative colitis ☐
- Crohn's disease ☐
- Irritable bowel syndrome ☐
- Constipation ☐

When you answer these questions, please think about how you have been in the **LAST WEEK.**

D10 Are you currently receiving ANY treatment or advice for any of these other bowel problems?

Yes ☐ *Go to **D10a*** No ☐ *Go to **Section E***

D10a If Yes, please give details of treatment or advice received for other bowel problems:

SECTION E – OTHER HEALTH ISSUES

This section is about exercise, weight and other issues to do with your health. When you answer these questions, please think about how you have been in the **LAST WEEK.**

E1 Have you done any general exercise or fitness activity?

Yes ☐ *Go to **E2*** No ☐ *Go to **E3***

E2 If Yes, what sort of exercise have you done? *(Tick **all** boxes that apply)*

Walking ☐ Swimming ☐

Gardening ☐ Running ☐

Going to the gym ☐ Other *(please give details in E2a)* ☐

E2a Please give details of other exercise:

E3 Have you done any pelvic floor exercises over the last week?

Yes ☐ *Go to **E4*** No ☐ *Go to **E5*** Don't know what these are ☐ *Go to **E6***

E4 If Yes, on how many days in the last week did you do pelvic floor exercises?
*(Tick **ONE** box only)*

Every day ☐

5 to 6 days ☐

3 to 4 days ☐

1 to 2 days ☐

When you answer these questions, please think about how you have been in the **LAST WEEK.**

E5 **How do you know about pelvic floor exercises?** *(Tick **ALL** boxes that apply to you)*

	Yes	No
From a doctor	☐	☐
From a nurse / continence advisor	☐	☐
From a physiotherapist	☐	☐
From leaflets or books	☐	☐
From the internet	☐	☐
From friends or family	☐	☐
From another source *(please give details in **E5a**)*	☐	☐

E5a **If from another source, please give details:**

E6 **Were you able to achieve an erection BEFORE your recent prostate surgery?**

Yes ☐ No ☐

E7 **Have you ever had a prostate operation BEFORE your recent prostate surgery?**

Yes ☐ No ☐

E8 **Please could you enter your weight and height?**
If you are not sure what they are, please give your best guess.
(Please use whichever units you are familiar with)

	Stones	Pounds	**OR**	Kilograms
What is your average weight now?	☐☐	☐☐		☐☐☐

	Feet	Inches	**OR**	Centimetres
What is your height?	☐☐	☐☐		☐☐☐

SECTION F – DESCRIBING YOUR OWN HEALTH TODAY

The next two sections are about your general health.

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

F1 Mobility

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

F2 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 ☐

F3 Usual activities *(such as 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 ☐

F4 Pain/discomfort

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

F5 Anxiety/depression

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

SECTION G – GENERAL HEALTH SF12 ©

The following questions ask for your views about your health **in the last 4 weeks,** how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

G1 **In general, would you say your health is:**
*(Tick **ONE** box only)*

- Excellent ☐
- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐

G2 **During a typical day does your health limit you in moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? If so, how much?**
*(Tick **ONE** box only)*

- Yes, limited a lot ☐
- Yes, limited a little ☐
- No, not limited at all ☐

G3 **During a typical day does your health limit you in climbing several flights of stairs? If so, how much?**
*(Tick **ONE** box only)*

- Yes, limited a lot ☐
- Yes, limited a little ☐
- No, not limited at all ☐

G4 **During the past 4 weeks, how often have you accomplished less than you would have liked in your work or other regular daily activities as a result of your physical health?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G5 **During the <u>past 4 weeks,</u> how often have you been limited in performing any kind of work or other regular daily activities as a result of your physical health?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G6 **During the <u>past 4 weeks,</u> how often have you accomplished less than you would have liked in your work or any other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G7 **During the <u>past 4 weeks,</u> how often have you done work or other activities less carefully than usual as a result of any emotional problems (such as feeling depressed or anxious)?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G8 **During the <u>past 4 weeks</u> how much did pain interfere with your normal work (both outside the home and housework)?**
*(Tick **ONE** box only)*

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

G9 **How much during the <u>past 4 weeks</u> have you felt calm and peaceful?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G10 **How much during the <u>past 4 weeks</u> did you have a lot of energy?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G11 **How much during the <u>past 4 weeks</u> have you felt downhearted and depressed?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

G12 **During the <u>past 4 weeks</u> how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**
*(Tick **ONE** box only)*

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

Sometimes we lose touch with our participants (for example if they move house). Would you please give us the name and contact details of someone such as a family member or close friend (a 'best contact') who might be able to give us your new address?

This 'best contact' should be someone who does **NOT** live at your own home.

BEST CONTACT

Title *(Mr, Mrs etc)*

Surname

First Names

Address

Postcode

Telephone Number *(including code)*

Relationship to yourself

Please could you let this person know that you have given us their details.

We would also like to tell your GP that you are helping with our MAPS study. Please could you give us his or her contact details

MY GENERAL PRACTITIONER:

Surname

First Name(s) *(if known)*

Address

Postcode

Telephone Number *(including code)*

PTO

Finally:

Date you filled in this questionnaire D D / M M / Y Y Y Y

Your date of birth D D / M M / Y Y Y Y

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out research into men's health after prostate surgery.

It will be treated with the strictest confidence and kept securely.

Please send the questionnaire back to us in Aberdeen in the envelope provided.

When we receive it, we will contact you to tell you which type of treatment you will receive, and to tell you what to do next.

Please could you confirm your phone number:

Thank you again for your help

If you would like any further information or have any queries about the study, please contact:

The MAPS Study Office in Aberdeen (Tel: 01224 551103)

This study is taking place in centres across the UK but the questionnaires are being processed in Aberdeen at the Health Services Research Unit, Polwarth Building, Foresterhill, ABERDEEN, AB25 2ZD.