

Health Economics Baseline Questionnaire

Use of health care services, medication and expenses incurred as a result of nausea or vomiting before chemotherapy

Instructions: Over the next few weeks we will need to ask you some questions about the health care services you have used and anything you have had to buy because of any nausea or vomiting you may have experienced following chemotherapy. We are doing this to find out the costs of the different approaches to treatment. This first questionnaire asks about any services used or anything you have had to buy because of any nausea or vomiting you have experienced in the last three weeks. Some questions will seem more relevant to you than others, but please try to answer all the questions so that we can compare the costs of the treatments fairly.

Your date of birth:

Hospital:

1. Please complete today's date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
DAY	MONTH	YEAR					

2. Please tick one box for the category that describes your present employment status.

Employment Status	Tick one category that best describes your employment now (please tick one box only)
a. Employee, full time (more than 30 hours/week)	<input type="checkbox"/>
b. Employee, part time (less than 30 hours/week)	<input type="checkbox"/>
c. Self-employed	<input type="checkbox"/>
d. Government-supported training	<input type="checkbox"/>
e. Other training or education	<input type="checkbox"/>
f. Employee on sick leave	<input type="checkbox"/>
g. Not in paid employment due to retirement	<input type="checkbox"/>
h. Not in paid employment for other reasons	<input type="checkbox"/>

If you are in paid work please tells us the number of days you have been away from work due to nausea or vomiting in the last three weeks.

No of days Not applicable

Please estimate the earnings lost by to absence from work due to nausea or vomiting in the last three weeks? (bring home earnings).

Earnings lost £ Not applicable

3. Have you used any health care services following nausea or because of vomiting in the last three weeks?

Type of service	Which services you have used in the last three weeks as a result of nausea or vomiting		Total number of <u>face to face</u> contacts	Total number of contacts you had by <u>telephone or e-mail</u>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
GP surgery visit	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
GP home visit	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
District nurse,	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Contact with oncology hotline for advice	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Contact with hospital oncology nurse clinician for advice	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Contact with hospital oncology clinic for advice	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Hospital inpatient stay	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Hospital accident and emergency department	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Hospital general outpatient clinic	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Other services. <i>Please specify in the boxes and for each service also provide number of contacts.</i>	1. <input type="text"/>	<input type="text"/>	1. <input type="text"/>	1. <input type="text"/>
	2. <input type="text"/>	<input type="text"/>	2. <input type="text"/>	2. <input type="text"/>
	3. <input type="text"/>	<input type="text"/>	3. <input type="text"/>	3. <input type="text"/>

4. Were you prescribed any medication for nausea or vomiting following use of any of the above services?

Type of service	Medication prescribed for nausea or vomiting?		Name of the medication	No. of times dose to be taken per day	Total No. of days medication prescribed	Cost to you
GP surgery visit	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
GP home visit	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
District nurse,	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Contact with oncology hotline for advice	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Contact with hospital oncology nurse clinician for advice	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Contact with hospital oncology clinic for advice	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Hospital inpatient stay	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Hospital accident and emergency department	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Hospital general outpatient clinic	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Other services. <i>Please specify in the boxes and for each service also provide number of contacts.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				

5. Did you incur any other expenses in the last three weeks due to nausea or vomiting?

Yes

No

6. If you have ticked 'Yes' to the previous question, please also describe the expenses that you have had to meet (for example, travel expenses, special diet or complementary therapy) in the table below.

Brief description of item	Cost to you (£'s)
	£ □□□□
	£ □□□□
	£ □□□□
	£ □□□□

7. For each of the five sets of statements below, please tick the one box that best describes your own health state today.

(i). Mobility

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

(ii). Self-care

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

(iii). 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.....

(iv). Pain/discomfort

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

(v). Anxiety/depression

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