Trial ID							

BASELINE QUESTIONNAIRE

(Pilot trial phase: Baseline assessment)

- There is no need to write your name on the questionnaire
- Please take your time and read each of the questions carefully
- If you are unsure about how to answer a question, please give the best answer you can
- There are no ‘right’ or ‘wrong’ answers – please answer as honestly as you can
- Ask the researcher if you need any help

Thank you

Section 1:

About You

This section asks some questions about you. Your answers will only be used for the purposes of this study.

1. What gender (sex) are you? *(Please tick one box)*

☐ Male ☐ Female

2. How old are you? _____ (years)

3. What is your ethnic group?

Please choose **one** section from A to E, and then tick the appropriate box to indicate your cultural background.

A. White

- ☐ British
- ☐ Irish
- ☐ Any other White background *(please write in)*

B. Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed background *(please write in)*

C. Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background *(please write in)*

D. Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background *(please write in)*

E. Chinese or other ethnic group

- ☐ Chinese
- ☐ Any other – *please write in*

4. What is your preferred language?

☐ English

☐ Other (please specify) _____

5. Which of the following best describes your current situation with regard to smoking? *(Please tick one box)*

☐	I have never smoked	*(Please go on to the next page)*
☐	I am an ex-smoker	*(Please go to Question 6 below)*
☐	I am a smoker (cigarettes, cigars or pipe)	*(Please go to Question 7 below)*

6. If you are an *ex-smoker*, when did you quit smoking?

Date you quit smoking: _____

(Please go on to Section 2 on the next page)

7. If you are a *current smoker*, how much do you smoke?

Number of cigarettes per day _____

Number of cigars per day _____

Pipe – ounces or grams of tobacco per week _____

Section 2:

Your current state of health

DUE TO COPYRIGHT RESTRICTIONS WE ARE UNABLE TO REPRODUCE THESE QUESTIONNAIRES IN THIS APPENDIX

- **EQ-5D-5L** – this includes five different statements about health status **TODAY**, with respondents given the opportunity to rate them on one of five levels.

- **EQ-VAS** – this includes a visual analogue scale (0–100) regarding how good or bad your health status is **TODAY**.

Section 3: Your emotional health

This section asks about different aspects of your emotional or mental health over recent weeks (including today). It includes three pre-printed questionnaires:

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- **BDI-II** – this includes 21 different groups of statements and you need to pick one statement from each group that best describes how you have been feeling during the **past two weeks**.

- **BAI** – this includes 21 different symptoms and you need to indicate how much you have been bothered by each symptom during the **past week**.

- **BADS-SF** – this includes 9 different statements and you need to indicate how much each statement has been true for you in the **past week.**

Please follow the instructions on each questionnaire – if you are not sure what to do or need help filling in the answers, please ask the researcher.

Section 4:
Looking after your emotional health

1. Do you believe that you have low mood?	
	Yes ❑
	No ❑

*If you answered **'Yes'** to Question 1*, please answer **Questions 2 and 3** below and **Questions 4 to 7** on the next page.

*If you answered **'No'** to Question 1,* please answer move on to **Section 5** (Page 21)**.**

We would like to know about your preferences for dealing with your low mood. We would also like to know how strongly you hold these preferences.

Please tick **one** option for each question

2. At this stage in your recovery, do you want any professional help for your low mood?	
I would **strongly prefer** to receive some form of help for my low mood	❑
I would **prefer** to receive some form of help for my low mood	❑
I would **prefer not** to receive any help for my low mood at this stage – I would prefer to see if the symptoms resolve naturally	❑
I would **strongly prefer not** to receive any help for my low mood at this stage – I would strongly prefer to see if the symptoms resolve naturally	❑

If you were to seek treatment for your low mood at this stage:

3. What TYPE of professional help would you prefer?	
I would **strongly prefer** help that is not drug-based (such as a talking therapy)	❑
I would **prefer** help that is not drug-based (such as a talking therapy)	❑
I would **prefer** a drug-based treatment	❑
I would **strongly prefer** a drug-based treatment	❑
I don't mind what type of help I receive	❑

We would like to know whether you are receiving any help or treatment for your low mood.

1. **Are you currently taking any anti-depressant medication (medicine to help with low mood)?**

☐	Yes	*Please go to Question 5*
☐	No	*Please go to Question 7*
☐	Not sure	*Please go to Question 7*

2. **Is your medicine for low mood prescribed by a qualified doctor?**

☐	Yes
☐	No

3. **For how long have you been taking your medicine for low mood?**

- ☐ Less than 6 weeks
- ☐ 6 weeks to 3 months
- ☐ More than 3 months

4. **Within the past 6 months, have you received any help for your low mood from:** please tick all that apply)

- ☐ Your general practitioner (GP)
- ☐ A hospital doctor or psychiatrist
- ☐ A therapist (such as a psychotherapist, CBT counsellor, psychologist, nurse or support worker)
- ☐ Another health or social care professional (please specify below)
- ☐ I have not received any help for my low mood

Section 5:

Your heart problem and how this affects you

Below is a list of common heart problems and heart-related procedures.

Please work down the list and, for each problem/procedure in turn, **circle 'No' or 'Yes' in Column A** to say whether you have ever been told by a doctor or nurse that you have had that heart problem or procedure.

If you don't know whether you have had a problem or procedure or not, please circle 'Not sure'. If you would like help to decide, please ask the researcher.

If you think you **have** had a problem or procedure, please tell us in **Column B when** this happened. If you know the month and year, please write that in. If you cannot remember the exact month and year, please give your best guess of how long ago it happened (e.g. '3 months ago').

	Column A			**Column B**
Heart problem or procedure	**Have you ever had this heart problem or procedure?**			**If 'Yes', when did this happen?**
Myocardial infarction ('heart attack')	No	Yes	Not sure	
Angina	No	Yes	Not sure	
Hospital admission with non-cardiac chest pain ('non-heart' chest pain)	No	Yes	Not sure	
Heart failure	No	Yes	Not sure	
Arrhythmia ('slow, fast and/or irregular heart beat')	No	Yes	Not sure	
Percutaneous Coronary Intervention or PCI ('balloon inflation of artery', with or without a 'stent')	No	Yes	Not sure	
Coronary Artery Bypass Grafting or CABG ('heart bypass')	No	Yes	Not sure	
Valve surgery	No	Yes	Not sure	
Any other heart problem or procedure (please specify below)	No	Yes	Not sure	

Section 6:

Other health problems

Below is a list of common health problems. Please work down the list and, for each health problem in turn, **circle 'Yes' or 'No'** to indicate whether you **currently** have that problem.

If you **do** have a particular health problem, please indicate: (a) whether you receive medication or some other type of treatment for the problem; and (b) whether the problem limits any of your activities.

Problem	Do you have this health problem?		If you do have this health problem: Do you receive treatment for it?		Does it limit your activities?	
Asthma	No	Yes	No	Yes	No	Yes
Lung disease, (including chronic obstructive pulmonary disease or COPD)	No	Yes	No	Yes	No	Yes
High blood pressure	No	Yes	No	Yes	No	Yes
Diabetes	No	Yes	No	Yes	No	Yes
Ulcer or stomach disease	No	Yes	No	Yes	No	Yes
Bowel disease	No	Yes	No	Yes	No	Yes
Kidney disease	No	Yes	No	Yes	No	Yes
Liver disease	No	Yes	No	Yes	No	Yes
Anaemia or other blood disease	No	Yes	No	Yes	No	Yes
Cancer	No	Yes	No	Yes	No	Yes
Nervous system disease (e.g. epilepsy, Parkinson's, dementia)	No	Yes	No	Yes	No	Yes
Arthritis	No	Yes	No	Yes	No	Yes
Back pain	No	Yes	No	Yes	No	Yes
Mental health problems	No	Yes	No	Yes	No	Yes
Skin disease (e.g. psoriasis)	No	Yes	No	Yes	No	Yes
Hearing or visual impairment	No	Yes	No	Yes	No	Yes
Any other health problems *(please write in)*			**For each health problem you list: Do you receive treatment for it?**		**Does it limit your activities?**	
			No	Yes	No	Yes
			No	Yes	No	Yes
			No	Yes	No	Yes
			No	Yes	No	Yes
			No	Yes	No	Yes

You have now reached the end of the study questionnaire.

Thank you for completing the information.