We are interested to know about various aspects of your health, following insertion of the stent and the effect the stent has had on your health.

Please complete the following questionnaire, which has different sections. Please answer all questions in each section.

(We would be grateful if you could complete and post the questionnaire within seven days)

Please complete:

Today’s Date:    /    /    

Date of Birth:   /    /    

Post Code:  

Hospital Number:  

(for office use)
You will see that some questions ask if you have a symptom occasionally, sometimes or most of the time.

- **Occasionally** = less than one third of the time
- **Sometimes** = between one and two thirds of the time
- **Most of the time** = more than two thirds of the time

**URINARY SYMPTOMS**

Please answer the questions thinking about the urinary symptoms you have experienced following insertion of the stent.

Please put a tick in one box for each question

Please think about your experience since insertion of the stent.

| Question | Options |
|----------|---------|
| U1. During the day, how often do you pass urine, on average? | Less than hourly | Every 3 hourly |
| | Hourly | Every 4 hours or more |
| | Every 2 hourly |
| U2. During the night, how many times do you have to get up to pass urine, on average? | None | 3 |
| | 1 | 4 |
| | 2 | 5 |
| U3. Do you have to rush to the toilet to urinate? | Never | Most of the time |
| | Occasionally | (more than two thirds for the time) |
| | Sometimes | (less than one third of the time) |
| | (between one and two thirds of the time) |
| U4. Does urine leak before you can get to the toilet? | Never | Most of the time |
| | Occasionally | All of the time |
| | Sometimes |
| U5. Do you leak urine without feeling the need to go to the toilet? | Never | Most of the time |
| | Occasionally | All of the time |
| | Sometimes |
### U6. how often do you feel that your bladder has not emptied properly after you have passed urine?

- Never [ ] 1
- Most of the time [ ] 4
- Occasionally [ ] 2
- (less than one third of the time)
- Sometimes [ ] 3
- (between one and two thirds of the time)
- All of the time [ ] 5

### U7. Do you have a burning feeling when you pass urine?

- Never [ ] 1
- Most of the time [ ] 4
- Occasionally [ ] 2
- All of the time [ ] 5
- Sometimes [ ] 3

### U8. How often do you blood in your urine?

- Never [ ] 1
- Most of the time [ ] 4
- Occasionally [ ] 2
- All of the time [ ] 5
- Sometimes [ ] 3

### U9. How much blood do you see in your urine?

- Do not see any blood [ ] 1
- Urine is heavily blood stained [ ] 3
- Urine is slightly blood stained [ ] 2
- Urine is heavily blood stained and has clot(s) [ ] 4

### U10. Overall, how much of a problem are your urinary symptoms to you?

- Not at all [ ] 1
- Quite a bit [ ] 4
- A little bit [ ] 2
- Extreme [ ] 5
- Moderate [ ] 3

### U11. If you were to spend the rest of your life with the urinary symptoms, if any, associated with the stent just the way they are, how would you feel about it?

- Delighted [ ] 1
- Mostly dissatisfied [ ] 5
- Pleased [ ] 2
- Unhappy [ ] 6
- Mostly satisfied [ ] 3
- Terrible [ ] 7
- Mixed feelings (about equally satisfied and dissatisfied [ ] 4

Please go to next section --
**BODY PAIN (for women):**

This section asks about the **body pain or discomfort**, which you associate with the stent.

Please think about your experience following insertion of the stent.

P1. Do you experience body pain or discomfort in association with the stent?

   YES 1, please go to question P2

   NO 2, please go to next section on General Health  (Ignore questions P2 to P9)

P2. Think of the drawings below as the drawings of your body. Please mark (X) or shade the site(s) where you experience pain or discomfort in association with the stent typically (e.g. during the day to day activities, whenever you pass urine)

   If you get pain at more than one site, please use a separate mark for each site.

   The numbers I - IV represent following areas for the right and left sides
   I - Kidney front/ side area
   II - Groin area
   III - Bladder area
   IV - Kidney back (loin) area

   Please use O for any other marked area and write the name of the site

P3. Please place a mark (X) to a point on the line below that indicates your pain or discomfort in association with the stent. **Please put a separate mark for each site** if the pain or discomfort is different in severity and write the corresponding number of each site used in the drawing above.

   No Pain or discomfort  Worst Possible Pain
BODY PAIN (for men):
This section asks about the **body pain or discomfort**, which you associate with the stent.

Please think about your experience **following insertion of the stent**.

**P1.** Do you experience body pain or discomfort in association with the stent?

**YES** 1. please go to question P2

**NO** 2. please go to next section on General Health  
(Ignore questions P2 to P9)

**P2.** Thinking the drawings below as the drawings of your body, **mark (X) or shade the site(s) where you experience pain or discomfort in association with the stent typically** (e.g. during the day to day activities, whenever you pass urine)

If you get pain at more than one site, please use a **separate mark for each site**.

![Image of a human body with areas marked]

The numbers I - V represent following areas for the right and left side.
- I – Kidney front/side area
- II – Groin area
- III – Bladder area
- IV – Kidney back (loin) area
- V – Penis

Please use **O** for any other marked site and name that site.

**P3.** Please place a mark (X) to a point on the line below that indicates your pain or discomfort in association with the stent. **Please put a separate mark for each site** if the pain or discomfort is different in severity and write the corresponding number of each site used in the drawing above.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
No Pain or discomfort | | | | | | | | | | Worst Possible Pain |
P4. Which of the following statements best describe your experience regarding physical activities and the pain or discomfort in association with the stent?

|   | Description                                                                                   |   |
|---|-----------------------------------------------------------------------------------------------|---|
| 1 | I do not experience any pain or discomfort during physical activities                         |
| 2 | I experience pain or discomfort only when I perform **vigorous activities** (e.g. strenuous sports, lifting heavy objects) |
| 3 | I experience pain when I perform **activities of moderate severity** but not with basic activities (e.g. walking few hundred yards, driving a car) |
| 4 | I experience pain when I perform **basic activities** of daily living (e.g. walking indoors, dressing) |
| 5 | I experience pain even when I perform basic activities of daily living (e.g. walking indoors, dressing) |

P5. Does the pain or discomfort, in association with the stent, interrupt your sleep?

|   | Description            |   |
|---|------------------------|---|
| 1 | Never                  |   |
| 2 | Occasionally           |   |
| 3 | Sometimes              |   |
| 4 | Most of the time       |   |
| 5 | All of the time        |   |

P6. Do you experience pain or discomfort, in association with the stent, while passing urine?

|   | Description            |   |
|---|------------------------|---|
| 1 | Never                  |   |
| 2 | Occasionally           |   |
| 3 | Sometimes              |   |
| 4 | Most of the time       |   |
| 5 | All of the time        |   |

P7. Do you experience pain or discomfort in the **kidney area**, while passing urine?

|   | Description |   |
|---|-------------|---|
| 1 | No          |   |
| 2 | Yes         |   |

P8. How frequently have you required painkillers to control the pain or discomfort associated with the stent?

|   | Description            |   |
|---|------------------------|---|
| 1 | Never                  |   |
| 2 | Occasionally           |   |
| 3 | Sometimes              |   |
| 4 | Most of the time       |   |
| 5 | All of the time        |   |

P9. Overall, how much does the pain or discomfort, in association with the stent, (as distinct from other symptoms) interfere with your life?

|   | Description            |   |
|---|------------------------|---|
| 1 | Never                  |   |
| 2 | Occasionally           |   |
| 3 | Sometimes              |   |
| 4 | Most of the time       |   |
| 5 | All of the time        |   |

Please go to next section --
**GENERAL HEALTH:**

Following insertion of the stent:

| Question                                                                 | Scale                          | Selection |
|--------------------------------------------------------------------------|--------------------------------|-----------|
| G1. Have you had difficulty in performing light physical activities       | (e.g. walking short distances,| Usually with no difficulty | 1        |
|                                                                          | driving a car)                  | Usually did not do because of the stent | 4        |
|                                                                          | Usually with some difficulty     | 2         |
|                                                                          | Usually with much difficulty     | 3         |
| G2. Have you had difficulty in performing heavy physical activities      | (e.g. strenuous sports, lifting | Usually with no difficulty | 1        |
|                                                                          | heavy objects)                   | Usually did not do because of the stent | 4        |
|                                                                          | Usually with some difficulty     | 2         |
|                                                                          | Usually with much difficulty     | 3         |
| G3. Have you felt tired and worn out?                                    |                                | Never 1   |
|                                                                          | Most of the time (more than two thirds of the time) | 4        |
|                                                                          | Occasionally (less than one third of the time) | 2        |
|                                                                          | Sometimes (between one and two thirds of the time) | 3        |
| G4. Have you felt calm and peaceful?                                     |                                | All of the time 1  |
|                                                                          | Occasionally (more than two thirds of the time) | 4        |
|                                                                          | Most of the time (less than one third of the time) | 2        |
|                                                                          | Sometimes (between one and two thirds of the time) | 3        |
| G5. Have you enjoyed your social life (going out, meeting friends and so |                                | All of the time 1  |
|                                                                          | Occasionally                     | 4        |
|                                                                          | Most of the time                 | 2        |
|                                                                          | Sometimes                       | 3        |
| G6. Have you needed extra help from your family members or friends?      |                                | Never 1   |
|                                                                          | Most of the time                 | 4        |
|                                                                          | Occasionally                     | 2        |
|                                                                          | Sometimes                       | 3        |

Please go to next section -
WORK PERFORMANCE:

W1. Regarding your employment status, are you

- In full time employment □ 1
- In part time employment □ 2
- Unemployed, looking for work □ 5
- Retired on health ground □ 3
- Retired for other reason (including age) □ 6
- Not working for other reason (please specify) □ 7

W2. Following insertion of the stent, how many days did the symptoms associated with the stent keep you in bed all or most of the day?

□ □ Day(s)

W3. Following insertion of the stent, for how many half days or more did you cut down your routine activities because of the symptoms associated with the stent?

□ □ Half Day(s)

Please answer the questions below (W4 - W7) only if you are in active paid work. (Otherwise ignore questions W4 - W7).

W4. a) Job title or description of your role: _________________________________

b) Are you an:  Employee □ 1  Employer □ 2  Self employed □ 3

Please answer following questions if you have worked after insertion of the stent,

W5. Have you worked for short periods of time or taken frequent rests because of the symptoms associated with the stent?

- Never □ 1  Most of the time □ 4
- Occasionally □ 2  All of the time □ 5
- Sometimes □ 3

W6. Have you worked at your usual job, but with some changes because of the symptoms associated with the stent?

- Never □ 1  Most of the time □ 4
- Occasionally □ 2  All of the time □ 5
- Sometimes □ 3

W7. Have you worked your regular number of hours?

- Never □ 1  Most of the time □ 4
- Occasionally □ 2  All of the time □ 5
- Sometimes □ 3

Please go to next section -
SEXUAL MATTERS:
Please tick one box for each question by thinking about your experience following insertion of the stent.

S1. Currently, do you have an active sex life?
No □ 1. Please answer question S2 and go to next section (Ignore questions S3 and S4).
Yes □ 2. Please go to question S3 (Ignore question S2).

S2. (i) If NO sex life, how long ago did this stop?
After insertion of the stent □ 1
Before insertion of the stent □ 0
(ii) AND, why did this stop?
Because of the problems associated with the stent □ 10
Did not attempt any sexual activity □ 0
Some other reason – not to do with the symptoms of the stent □ 0
( Ignore questions S3 – S4 )

Please answer questions S3 and S4, only if you have answered ‘yes’ to question S1.

Please think about your experience following insertion of the stent.

S3. Do you have pain when you have sexual intercourse?
Not at all □ 1
Mild □ 2
Moderate □ 3
Severe □ 4
Extreme □ 5

S4. How satisfied are you with your sex life?
Very satisfied □ 1
Satisfied □ 2
Not sure □ 3
Dissatisfied □ 4
Very dissatisfied □ 5

Please go to next section ---
ADDITIONAL PROBLEMS:
The following questions ask about your experience following insertion of the stent. Please indicate your experience by ticking the appropriate box.

**A1. How many times have you felt you may be suffering from a urinary tract infection (e.g. running temperature, feeling unwell and pain while passing urine)?**

- Never □ 1
- Occasionally □ 2
- Sometimes □ 3
- Most of the time □ 4
- All of the time □ 5

**A2. Have you needed to take antibiotics as a result of insertion of the stent? (Please ignore the course of antibiotics, which may have been given at the time of insertion of the stent.)**

- Not at all □ 1
- One Course □ 2
- Two Courses □ 3
- Three or more Courses □ 4

**A3. Have you needed to seek help of a health professional (such as GP, nurse) due to any problem associated with the stent?**

- Never □ 1
- Once □ 2
- Twice □ 3
- Three or more times □ 4

**A4. Have you needed to visit the hospital due to any problem associated with the stent?**

- Never □ 1
- Once □ 2
- Twice □ 3
- Three or more times □ 4

**GQ In the future, if you were advised to have another stent inserted, how would you feel about it?**

- Delighted □ 1
- Pleased □ 2
- Mostly satisfied □ 3
- Mostly dissatisfied □ 4
- Unhappy □ 5
- Terrible □ 6

**AQ. If there are any comments you would like to make about the questionnaire or any of your symptoms, please use the space below.**

THANK YOU VERY MUCH FOR YOUR HELP
All information will remain confidential