

## CONDUCT study patient questionnaire

Patient ID: \_\_\_\_\_

Today's date: \_\_\_\_\_

Thank you for agreeing to take part in our study, which we hope will lead to improvements in the care of women with symptoms of urinary tract infection.

This questionnaire has two sections.

**Section 1:** We would like you to tell us about your health today

**Section 2:** We would like you to tell us about your symptoms, your history of urine infections and a little bit about yourself



**Health Questionnaire**

**English version for the UK**

Under each heading, please tick the ONE box that best describes your health TODAY.

**MOBILITY**

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

**SELF-CARE**

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe 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 doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

**PAIN / DISCOMFORT**

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

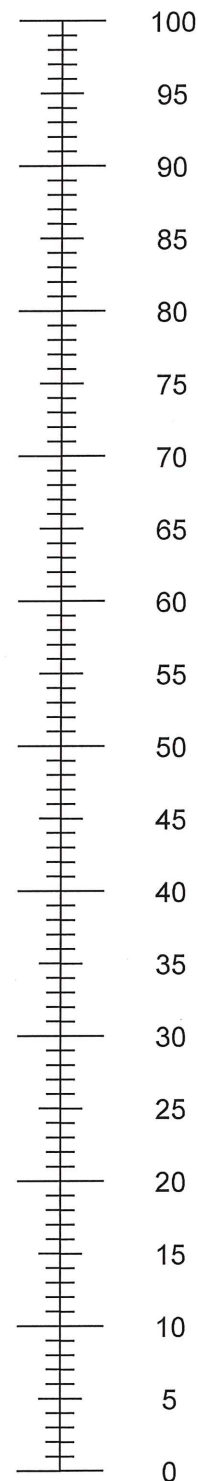
**ANXIETY / DEPRESSION**

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely 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

## Section 2

### A: Information about your symptoms of a possible urine infection

1. In the **last seven days** have you **visited or contacted** the following services due to your symptoms of possible urinary tract infection (such as burning when you pass urine, feeling generally unwell, or needing to go more often)?

	YES	NO	How many times?
GP			
District/community nurse at home			
Practice nurse			
Out-patient clinic			
Doctor/nurse in an accident and emergency department			
Out of hours GP			
Ambulance			
Pharmacist			

2. Have you used any treatments (for example, that you bought from a pharmacy) for your symptoms of urinary tract infection in the last 7 days?

Yes	
No	

If yes, what have you used to treat your symptoms? Please tick any that you have used. Product		Number of days you have used the product
Paracetamol		
Ibuprofen		
Sodium citrate e.g. Boots Cystitis Relief sachets		
Potassium citrate sachets		
Cranberry Juice including extract		
D-Mannose		
Other		

### 3. Please rate your current symptoms

Using the scoring system below, please tick a number for each symptom to tell us how bad each symptom is at the moment:

For example, if you think fever is as bad as it could be, then you would tick the 6 box. If you do not have a fever you would tick the 0 box

Score	Severity of symptom/problem
0	Normal / Not affected
1	Very little problem
2	Slight problem
3	Moderately bad
4	Bad
5	Very Bad
6	As bad as it could be

Severity of symptoms Please tick one for each symptom	0	1	2	3	4	5	6
Fever							
Pain in your side or back with this illness							
Blood in urine							
Smelly Urine							
Burning or pain when passing urine							
Urgency (having to go in a hurry)							
Daytime frequency (going more often than usual during the day)							
Night time frequency (going more often than usual during the night)							
Tummy pain							
Can't do usual daily activities							
Feeling generally unwell							
Vaginal discharge which is not normal for you							
Vaginal irritation							
Nausea (feeling sick)							
Vomiting (being sick)							
Feeling shivers or chills							
Producing larger amounts of urine than usual							



**4. How easy was it for you to use the urine collection technique you were allocated to?**

Very Easy	Easy	Neither easy or difficult	Difficult	Very difficult
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**5. How confident are you that you have a urine infection today?**

Not at all confident	Not very confident	Moderately confident	Confident	Very confident
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**B: Your history of urine infections**

**1. Have you ever had a urine infection diagnosed by a doctor or nurse at any point in the past (please do not count this current episode)?**

Yes	
No	
Do not know	

If you have answered **No** or **Do not know** then please go to **Part C**

**2. How many times have you been treated with antibiotics for a urine infection in the past year?**

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**3. If you have had a urine infection in the past year, how many months ago did you have the last one before the current one?**

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**4. How many times have you had symptoms of a urine infection in the last year for which you DID NOT see a doctor or nurse?**

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**5. Do you suffer with episodes of urine incontinence (leaking)?**

Yes	
No	

If yes: Does this happen more than once a month?

Yes	
No	

**C: About you:**

**1. Are you pregnant?**

Yes	
No	

**2. Have you gone through the menopause?**

Yes	
No	
Don't know	

**3. Education (please tick one box that suits you best. If you are not sure, just give us your best guess)**

No formal qualifications	
1-4 GCSEs or equivalent	
5 GCSEs or equivalent	
Apprenticeships	
2 or more A-levels or equivalent	
Higher National Diploma or equivalent	
University Bachelors degree or equivalent, and higher qualifications	
Other qualifications including foreign qualifications	
Please specify:	

Research has found that sexual intercourse may increase the chances of urine infection. We are asking the following questions to find out if this is true or not.

**4. How often do you generally have sexual intercourse? Please select one option.**

Not in the past year	
A few times per year to monthly	
A few times per month to weekly	
2-3 times per week	
4 or more times per week	
Prefer not to say	



Yes	
No	
Not applicable	
Prefer not to say	

Always	
Sometimes	
Never	
Prefer not to say	

Always	
Sometimes	
Never	
Prefer not to say	

Always	
Sometimes	
Never	
Prefer not to say	

[illegible]

## Thank you!

Thank you very much for taking the time to complete this questionnaire

Please take away our follow up questionnaire to complete on day 14

**Please keep a record of when your symptoms of possible urinary tract infection resolve**

We will telephone you to collect your responses on or after 14 days from today