

## CONDUCT study patient questionnaire

**For completion 14 days after entering the study: we will telephone you to collect your responses**

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

Date this form was completed: \_\_\_\_\_

Thank you for your continuing support for our study, which we hope will lead to improvements in the diagnosis and management of women with symptoms of urinary tract infection.

This questionnaire has two sections.

**Section 1:** This is the same as the first part of the questionnaire you completed for us at the GP surgery when you were recruited to the study, but it asks for information about your health NOW. This is because we want to see how your health has changed over the time you have been enrolled on the study.

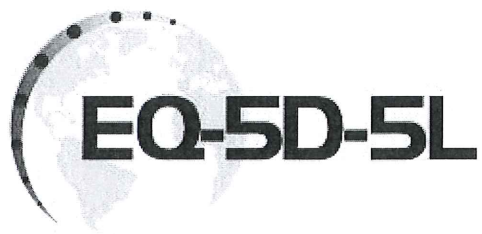
**Section 2:** This is for you to tell us how long it took for your symptoms to resolve and which health care services and medications you have used in the past 2 weeks.

*Please complete this questionnaire at home on DAY 14 of your participation in the CONDUCT study. We will telephone you to collect your responses.*

If you have any queries, please contact the study co-ordinator:

Sarah Tearne – Telephone: 01865 617958 or email [sarah.tearne@phc.ox.ac.uk](mailto:sarah.tearne@phc.ox.ac.uk)

Thank you very much for your cooperation



## **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**

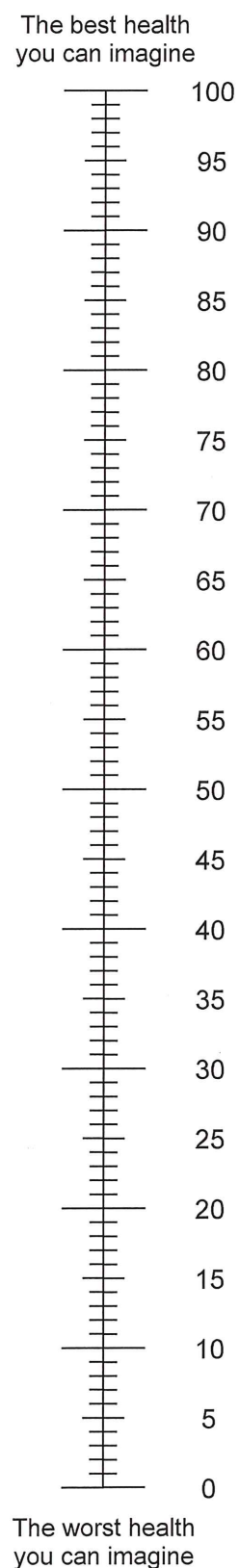
- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

**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 =



Section One: EQ-5D-5L questionnaire

[http://www.euroqol.org/fileadmin/user\\_upload/Documenten/PDF/Products/Sample\\_UK\\_English\\_EQ-5D-5L\\_Paper\\_Self\\_complete\\_v1.0\\_ID\\_24700\\_.pdf](http://www.euroqol.org/fileadmin/user_upload/Documenten/PDF/Products/Sample_UK_English_EQ-5D-5L_Paper_Self_complete_v1.0_ID_24700_.pdf)

Section Two: Your symptoms and your use of health services

1. Have your symptoms of urinary tract infection got completely better?

Yes	
No	

If YES – HOW many days after you entered our study did it take for your symptoms to get completely better?

Number of days	
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If you still have symptoms of urinary tract infection, 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)							

Continued	0	1	2	3	4	5	6
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							
Feeling shivers or chills							
Producing larger amounts of urine than usual							

**2. Over the last 14 days, how many times you have visited or contacted the following services with symptoms or problems (such as burning when you pass urine, feeling generally unwell, or needing to go more often) related to a possible urinary tract infection?**

	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			

**3. Apart from the sample you gave when you joined our study, have you provided any further urine samples to your GP, or another doctor or nurse?**

Yes	
No	



IF YES:

	Sample 1			Sample 2			Sample 3		
Who asked you to do this?									
Was the sample sent to the laboratory?	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know

4. Have you taken any antibiotics for any reason since you joined this study?

Yes		
No		If NO please go to question 5

If YES: Please tell us more about **all** the antibiotics you have taken since joining our study using the table below. Please fill in one column for **each antibiotic** you have used:

	Antibiotic 1		Antibiotic 2		Antibiotic 3	
Were they to treat a urine infection?	Yes	No	Yes	No	Yes	No
Name of the Antibiotic						
Dose and how many times a day?						
Number of days after entering the study you started taking them						
Number of days you took them for						
Where did you get them from? (tick one)						
<i>My GP prescribed them on the day I joined the study</i>						
<i>Prescribed by another doctor after I joined the study</i>						
<i>I had them at home</i>						
<i>Other</i>						

5. Have you used any other treatments (for example, that you bought from a pharmacy) for your symptoms of urinary tract infection since you joined the study?

Yes	
No	

If yes, please tick the treatments you used:

Product	Number of days you have used the product
Paracetamol	
Ibuprofen	
Sodium citrate e.g. Boots Cystitis Relief sachets	
Potassium citrate sachets	
Bicarbonate of soda	
Cranberry Juice including extract	
D-Mannose	
Other:	

6. Over the last 14 days, has a doctor prescribed any other medications for you apart from the ones you have told us about in questions 4 and 5 above?

Yes	
No	

If yes, please tell us the names of the medications and the reason you were given them

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7. Over the last 14 days, have you had any overnight stays in hospital?

Yes	
No	

If yes:

Number of hospital stays	
Total number of nights in hospital	
Reason for hospital stay	



Thank you for your participation in the CONDUCT study, we will ring you soon to collect your responses to this questionnaire.