LENT / SOMA PATIENT QUESTIONNAIRE

ID No: _____

Date Completed: _____

(PLEASE ANSWER QUESTIONS AS TO HOW YOU'VE BEEN FEELING OVER THE LAST 2 WEEKS ONLY, BY CIRCLING THE APPROPRIATE ANSWER)

Please state if you have had any operations relating to your bowels and when this took place

_____

Do you get any pain when you open your bowels?

0 = No
1 = Rarely
2 = Sometimes
3 = Often
4 = Always

If Yes, how severe is this pain?

1 = Minimal
2 = Tolerable
3 = Intense
4 = Excruciating

When you feel a desire to open your bowels do you need to go straight away?

0 = No
1 = Monthly
2 = Weekly
3 = Daily
4 = Constantly

How often have you felt the desire to open your bowels urgently and were unable to?

0 = Never
1 = Monthly
2 = Weekly
3 = Daily
4 = Constantly

Have you had any diarrhoea recently?

0 = No
1 = Yes

If Yes, how many times do you have diarrhoea each day?

_____

Do you have any difficulty in controlling your bowels? (e.g. any accidents)

0 = No
1 = Yes

If Yes, how often?

1 = Monthly
2 = Weekly
3 = Daily
4 = Constantly

(PLEASE CIRCLE THE APPOPRIATE NUMBER)

Have you had any bleeding recently when you've opened your bowels?

0 = No
1 = Yes

If Yes, how often have you noticed this?

_____

Have you recently suffered with constipation?

0 = No
1 = Yes

If Yes, how often do you open your bowels?

0 = More than 4 times per week
1 = 3-4 per week
2 = 2 per week
3 = only 1 per week
4 = Less than this

Have you passed any black motions recently?

0 = No
1 = Yes

If Yes, how often have you noticed this?

1 = Monthly
2 = Weekly
3 = Daily
4 = Constantly

Please could you state your weight

_____

Have you passed any sticky / slimy motions recently?

0 = No
1 = Rarely
2 = Sometimes
3 = Often
4 = Always

Are you taking any tablets for diarrhoea?

0 = No
1 = Yes

If Yes, please give name

_____

How often do you take this in any one week?

1 = Less than 2 tablets per week
2 = 2 or more tablets per week

Please give the names of any other medication you are taking for your bowels and how often you take this

_____

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

The next section refers to your bladder

Please state if you have had any operations relating to your bladder and when this took place

_____

Are you getting any pain on passing urine?

0 = None
1 = Rarely
2 = Sometimes
3 = Often
4 = Always

If Yes, how severe is this pain?

1 = Minimal
2 = Tolerable
3 = Intense
4 = Excruciating

When you feel a desire to pass urine do you need go straight away?

0 = No
1 = Monthly
2 = Weekly
3 = Daily
4 = Constantly

Have you had any blood in your urine recently?

0 = No
1 = Rarely
2 = Sometimes
3 = Often with clot
4 = Always

How frequently do you pass urine?

0 = Less than every 4 hours
1 = Once every 3-4 h
2 = Once every 2-3 h
3 = Once every 1-2 h
4 = Every hour

Do you have to get up during the night to pass urine?

0 = No
1 = Yes

If Yes, please state how many times?

0 = 0 - 1
1 = 2 - 3
2 = 4 - 6
3 = 7 or more

Do you suffer with incontinence of urine?

0 = None
1 = Less than every week
2 = Less than every day
3 = Several times a day
4 = All the time

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

Is your flow of urine weaker now than before Radiotherapy treatment?

0 = No
1 = Yes
8 = I have not had radiotherapy treatment yet

If Yes, how often have you noticed this?

1 = Monthly
2 = Weekly
3 = Daily
4 = Needed catheter

Are you taking any medication for you bladder?

0 = No
1 = Yes

If Yes, please state the name of your medication & how often you take this

_____

Are you getting any tiredness and headaches together?

0 = No
1 = Yes

Are you passing less urine now than you usually do?

0 = No
1 = Yes

Are your ankles swollen?

0 = No
1 = Yes

The next section is about your sexual function and sexual satisfaction and although the following questions are very personal, your answers will be treated in strict confidence and will remain anonymous.

Do you suffer with vaginal dryness?

0 = No
1 = Yes

If Yes, how often?

1 = Monthly
2 = Weekly
3 = Daily
4 = Constantly

Are you using a cream for vaginal dryness?

0 = No
1 = Yes

If yes, please state name

_____

How often do you use this?

1 = Monthly
2 = Weekly
3 = Daily

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

Are you getting any pain from the vagina?

0 = No
1 = Rarely
2 = Sometimes
3 = Often
4 = Always

If Yes, how severe is this pain?

1 = Minimal
2 = Tolerable
3 = Intense
4 = Excruciating

Are you taking any painkillers for this pain?

0 = No
1 = Yes

If Yes, what are your painkillers called & how often do you take these?

_____

Are you experiencing pain with intercourse?

0 = No
1 = Rarely
2 = Sometimes
3 = Often
4 = Always
8 = Not sexually active
9 = Don't want to answer

To what extent have you been interested in sex recently?

0 = Always
1 = Often
2 = Sometimes
3 = Rarely
4 = Never
9 = Don't want to answer

Has your interest in sex altered since your treatment?

0 = No
1 = Yes
8 = I have not had radiotherapy treatment yet
9 = Do not wish to answer

At present how does your frequency of intercourse compare to what is usual for you?

0 = Same as usual
1 = Less than usual
2 = Much less than usual
8 = Not sexually active
9 = Don't want to answer

Do you find this a problem?

0 = No
1 = Yes
9 = Don't want to answer

Do you get satisfaction?

0 = Always
1 = Often
2 = Sometimes
3 = Very rarely
4 = It is never satisfying
8 = Not sexually active

9 = Don't want to answer

Has your sex life changed since your treatment?

0 = No
1 = Yes
8 = I have not had radiotherapy treatment yet
9 = Don't want to answer

Would you like any of the issues raised in these questionnaires to be brought to the attention of your treating team?

⑨ **No** ⑨ **Yes**

Many Thanks for completing this questionnaire.