



Your Health Survey

Why this questionnaire

You may already have heard about renal units introducing health questionnaires. This is part of a national project. The purpose of these questionnaires is to find out how your kidney disease affects you when you are at home looking after yourself, leading your daily life with family and carers.

This can help you and your renal team in the decisions about your treatment that affect how you can live your life. Research has shown that being involved in this way can give you more control and confidence over treatment decisions, support you in achieving your goals and can improve your health and well-being.

Completing the questionnaire

The following questions are about **your** symptoms, **your** health, and how **you** manage it. This is about **your** experiences and opinions; there are no "right" or "wrong" answers. Think about your life as a whole, not just your kidney problems.

These questions should take about 10 minutes to complete. You can ask your partner, a friend or family member, or one of the staff to help you. Choosing not to take part will not affect your care in any way. Once you have completed the survey please hand in to a member of staff in the department. During your appointment, your doctor or nurse will discuss with you your responses to the questions about your health and how you manage it.

Protecting patient information

The NHS has strict rules which protect patient information. By completing the questionnaire you are consenting to your answers being sent to and held by the UK Renal Registry and your renal unit. Please contact the Registry at sarah.evans@renalregistry.nhs.uk or 0117 414 8151 if you have any questions or concerns about the way your information is held.

Thank you for participating in this survey.

For each question please use a black or blue pen

Centre number

Subject initials

Sequential patient number

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<input type="text"/>							

Forename:

<input type="text"/>																		
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Surname:

<input type="text"/>																		
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Renal Unit:

<input type="text"/>																		
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Date of birth:

<input type="text"/>																		
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Home Post Code:

<input type="text"/>																		
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Date completed:

<input type="text"/>																		
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NHS number:

<input type="text"/>																		
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(for staff use)

Renal Unit Post Code:

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(for staff use)

Please turn over the page

YOUR SYMPTOMS

Below is a list of symptoms, which you may or may not have experienced. For each symptom, please put a **X** in the box that best describes how it has affected you over the past week.

	<i>Not at all</i>	<i>Slightly</i>	<i>Moderately</i>	<i>Severely</i>	<i>Overwhelmingly</i>
Pain	<input type="checkbox"/>				
Shortness of breath	<input type="checkbox"/>				
Weakness or lack of energy	<input type="checkbox"/>				
Nausea (feeling like you are going to be sick)	<input type="checkbox"/>				
Vomiting (being sick)	<input type="checkbox"/>				
Poor appetite	<input type="checkbox"/>				
Constipation	<input type="checkbox"/>				
Sore or dry mouth	<input type="checkbox"/>				
Drowsiness	<input type="checkbox"/>				
Poor mobility	<input type="checkbox"/>				
Itching	<input type="checkbox"/>				
Difficulty sleeping	<input type="checkbox"/>				
Restless legs or difficulty keeping legs still	<input type="checkbox"/>				
Changes in skin	<input type="checkbox"/>				
Diarrhoea	<input type="checkbox"/>				
Feeling anxious or worried about your illness or treatment	<input type="checkbox"/>				
Feeling depressed	<input type="checkbox"/>				

Please turn over the page

YOUR OVERALL HEALTH

Under each heading, please mark ONE box with X 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, 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*

Please turn over the page

MANAGING YOUR HEALTH

Mark X in the box for the answer that is most true for you today.

If the statement does not apply mark N/A

	<i>Disagree Strongly</i>	<i>Disagree</i>	<i>Agree</i>	<i>Agree Strongly</i>	<i>N/A</i>
I am the person who is responsible for taking care of my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking an active role in my own healthcare is the most important thing that affects my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident I can help prevent or reduce problems associated with my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what each of my prescribed medications do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I can tell a doctor or nurse concerns I have even when he or she does not ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I can carry out medical treatments I may need to do at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand my health problems and what causes them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what treatments are available for my health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been able to maintain lifestyle changes, like healthy eating or exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to prevent problems with my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident I can work out solutions when new problems arise with my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I can maintain lifestyle changes, like healthy eating and exercising, even during times of stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn over the page

Where did you complete this questionnaire?

At home

Renal Unit

Clinic

GP Practice

How did you complete this questionnaire?

On my own

*With help from a friend or
relative*

*With help from a member
of staff*

Thank you for completing this questionnaire

For further information please visit the Transforming Participation in CKD Website
<https://www.thinkkidneys.nhs.uk/ckd/>

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'Your Symptoms' section based on Integrated Palliative Outcome Scale – Renal (IPOS-Renal-P7). More information available from "<http://www.pos-pal.org>".

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