FOR OFFICE USE ONLY

Randomisation No. R _ _ / _ _ _

Participant Initials _ _ _

# Participant Questionnaire

## Baseline

### Confidential

Thank you for helping us with our research. We would be very grateful if you could complete this questionnaire.

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The following questionnaire is broken down into four sections (Section A - Section D). Please work through all the sections as best you can from start to finish.
Each section asks you to indicate your answers to the questions by placing a tick (✓) in the appropriate box. Please read the questions carefully and answer each one as accurately as you can.

**There are no right or wrong answers.**

**Please try to complete the whole questionnaire even though some questions may appear similar.**

***Your answers will be treated with complete confidentiality.***

***Thank you for your time in completing this questionnaire.***

## Please start here:

Date of completion ☐☐ ☐☐ ☐☐☐☐
d d m m y y y y

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# Section A: Describing your own health today (EQ-5D)

## Your own health today

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today

A1 **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 ☐

A2 **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 ☐

A3 **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 ☐

A4 **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 ☐

A5 **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 ☐

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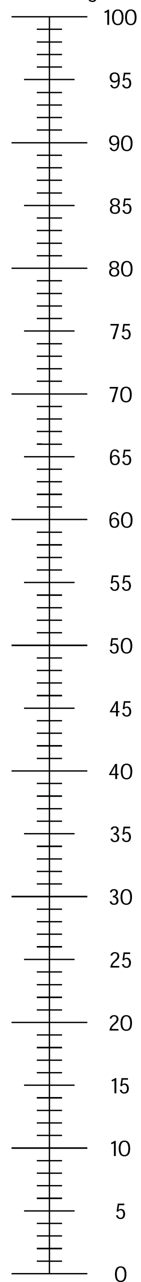
## Section A: Describing your own health today (EQ-5D)

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100
- 100 means the <u>best</u> health you can imagine.
  0 means the <u>worst</u> 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

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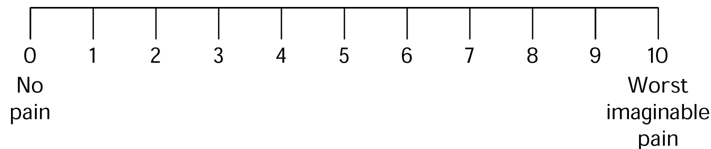
## Section B: Your level of pain

B1 **Please rate the level of pain related to your haemorrhoids that you are experiencing TODAY.**

The best rating is marked 0 (no pain) and the worst rating is marked 10 (worst imaginable pain). Please draw a circle around the most appropriate number that describes your pain today.




B2 During the last 7 days have you been taking any pain relief medication?

☐ Yes ☐ No

B3 How many days, out of the last 7, have you taken any pain relief medication?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

## Section C: Assessment of faecal (stool) incontinence

Please tick the box which best describes your symptoms during the past four weeks:

| | Never* | Rarely* | Sometimes* | Weekly* | Daily* |
|---|---|---|---|---|---|
| C1 Incontinence of solid stool | ☐ | ☐ | ☐ | ☐ | ☐ |
| C2 Incontinence of liquid stool | ☐ | ☐ | ☐ | ☐ | ☐ |
| C3 Incontinence of gas | ☐ | ☐ | ☐ | ☐ | ☐ |
| C4 Affects your lifestyle | ☐ | ☐ | ☐ | ☐ | ☐ |

*Never = no episodes in the past four weeks; rarely = 1 episode in the past four weeks; sometimes = >1 episode in the past four weeks but <1 a week; weekly = 1 or more episodes a week but <1 a day; daily = 1 or more episodes a day.

C5 Are you able to delay defaecation ("hold on") for at least 15 minutes? ☐ Yes ☐ No

C6 Are you taking constipating medicines? ☐ Yes ☐ No

C7 Do you need to wear a pad or plug? ☐ Yes ☐ No

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## Section D: Haemorrhoids symptom score

Please tick the box which best describes your symptoms during the past four weeks:

| | Never* | Sometimes* | Weekly* | Daily* |
|---|---|---|---|---|
| D1 How often do you experience pain from the haemorrhoids? | ☐ | ☐ | ☐ | ☐ |
| D2 How often do you experience itching or discomfort of the anus? | ☐ | ☐ | ☐ | ☐ |
| D3 How often do you experience bleeding when passing a motion? | ☐ | ☐ | ☐ | ☐ |
| D4 How often do you soil your underwear (mucous, liquid or solid discharge)? | ☐ | ☐ | ☐ | ☐ |
| D5 How often do you have to push back in a prolapsing haemorrhoid? | ☐ | ☐ | ☐ | ☐ |

*Never = no episodes in the past four weeks; sometimes = >1 episode in the past four weeks but less than once per week; weekly = 1 - 6 times per week; daily = every day (1 or more episodes a day).

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Thank you very much for being part of the HubBLe study and for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us to inform patients and doctors about haemorrhoid surgery in the future. It will be treated with the strictest confidence and kept securely.