Pre-Discharge Patient Questionnaire

Resize Text

Thank you for participating in this important study. We are asking patients about their physical and emotional function, and pain as a way to understand how to improve care at UCSF. Your responses to this questionnaire will be kept confidential and will not be shared outside our research and quality improvement team.

This survey should take no more than 10 minutes to complete. If you have questions, please call Dr. Andrew Auerbach (415-502-1945) or email Email.Study@ucsf.edu

This project is sponsored by the Centers for Disease Control. As a federally-supported study, we are providing you the following information.

Form Approved
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I would like to ask you some questions about your health over the month or so before you came to the hospital.

In general, would you say your health in the month before you came to the hospital was:

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

reset

The following questions are about activities you might do during a typical day. Did your health limit you in these activities in the month before you came to the hospital? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:	○	○	○
Climbing several flights of stairs:	○	○	○

reset

reset

In the month or so before you came to the hospital, how much of the time did you have any of the following problems with your work or other regular daily activities as a result of your *physical health*?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Accomplish less than you would like	○	○	○	○	○
Were limited in the kind of work or other activities	○	○	○	○	○

reset

reset

In the month or so before you came to the hospital, how much of the time did you have any of the following problems with your work or other regular daily activities as a result of any *emotional problems (such as feeling depressed or anxious)*?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Accomplish less than you would like	○	○	○	○	○
Did work or activities less carefully than usual	○	○	○	○	○

reset

In the month or so before you came to the hospital, how much did pain interfere with your normal work (including both work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

reset

These questions are about how you feel and how things have been with you during the month or so before you came to the hospital. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the month or so before you were admitted to the hospital...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○
Have you felt downhearted and depressed?	○	○	○	○	○

reset

reset

reset

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
In the month or so before you came to the hospital, how much of the time did your *physical health* or *emotional problems* interfere with your social activities (like visiting with friends, relatives, etc.)?	○	○	○	○	○

reset

Thinking about the month or so before you came to the hospital:

	Yes	No	Don't know/refuse	Not applicable
Did you use any equipment such as a cane, crutches, or walker to walk?	○	○	○	○
Did you need help washing or bathing yourself?	○	○	○	○
Did you need help dressing and undressing?	○	○	○	○
Did you need help eating, including cutting food?	○	○	○	○
Did you need help getting in and out of the bed and the chair?	○	○	○	○

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Thinking about the month or so before you came to the hospital, were you able to do the following things without help or with difficulty, and/or did you need help from others?

	Need no help	Need some help	Unable to do	Do not do
Shop for groceries or clothes?	○	○	○	○
Prepare, serve and provide meals for yourself?	○	○	○	○
Do light housework, such as dusting or doing dishes?	○	○	○	○
Get to places out of walking distance by using public transportation or driving a car?	○	○	○	○
Take pills or medicines in the correct amounts and at the correct times?	○	○	○	○

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If you needed help with basic personal care activities like eating or dressing, do you have relatives or friends (besides your husband/wife/partner) who would be willing and able to help you over a long period of time?

○ Yes ○ No ○ Don't know ○ Refuse ○ Not Applicable

reset

Questions about falls

In the past 12 months how many times have you fallen?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many of these falls caused an injury? By injury, we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

In the past 12 months, who has talked to you about your risk of falling? Check all that apply.

- ☐ Doctor
- ☐ Physician assistant/Nurse practitioner
- ☐ Pharmacist
- ☐ Nurse
- ☐ Another health care provider
- ☐ Family member or caregiver
- ☐ Other
- ☐ No one has talked to me

In the past 12 months, who has talked to you about medicines such as pain medicines that might make you fall? Check all that apply.

- ☐ Doctor
- ☐ Physician assistant/Nurse practitioner
- ☐ Pharmacist
- ☐ Nurse
- ☐ Another health care provider
- ☐ Family member or caregiver
- ☐ Other
- ☐ No one has talked to me

On a scale from 1 to 5, where 1 means "not at all important" and 5 means "most important," how important is falling compared with your other health concerns?

○ 1 (not at all important) ○ 2 ○ 3 ○ 4 ○ 5 (most important)

reset

On a scale from 1 to 5, where 1 means "not at all likely" and 5 means "very likely," how likely are you to fall?

○ 1 (not at all likely) ○ 2 ○ 3 ○ 4 ○ 5 (very likely)

reset

On a scale from 1 to 5, where 1 means "not at all likely" and 5 means "very likely." If you fell, how likely would you be to get hurt?

○ 1 (not at all likely) ○ 2 ○ 3 ○ 4 ○ 5 (very likely)

reset

On a scale from 1 to 5, where 1 means "strongly disagree" and 5 means "strongly agree", indicate your agreement with the following statement: "Older people fall and there is nothing that can be done about it."

○ 1 (strongly disagree) ○ 2 ○ 3 ○ 4 ○ 5 (strongly agree)

reset

In the last three months, on average, how many days per week have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

- ○ 0 or < 1 day per week
- ○ 1 day per week
- ○ 2 days per week
- ○ 3 or more days per week
- ○ Don't know
- ○ Prefer not to answer

reset

Considering all types of alcoholic beverages, how many times during the last three months did you have 5 or more drinks on an occasion?

- ○ None
- ○ 1 time
- ○ 2 times
- ○ 3 or more times
- ○ Don't know
- ○ Prefer not to answer

reset

Questions about PAIN and how you take care of your PAIN.

Do you have one or more conditions that cause(s) you pain?

- ○ Yes
- ○ No

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Over the last 6 months, on about how many days have you had pain?

- ○ I have had pain, but on less than half of the days
- ○ I have had pain on more than half of the days but not every day
- ○ I have had pain every day, but not all the time
- ○ I have had pain all day, every day, without break

reset

What number best describes your pain on average in the past week? (from 0=no pain to 10=pain as bad as you can imagine)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

reset

What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0=does not interfere to 10=completely interferes)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

reset

What number best describes how, during the past week, pain has interfered with your general activity? (from 0=does not interfere to 10=completely interferes)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

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Do you do any of the following for your pain? Check all that apply.

- ☐ Yoga, stretching, or range of motion exercises
- ☐ Massage or chiropractic
- ☐ Acupuncture or cupping
- ☐ Meditation or counseling
- ☐ Prayer or spiritual practices
- ☐ Marijuana in any form

Do you regularly take medications for your pain?

○ Yes ○ No ○ Refuse

reset

Which kinds of medications do you take for pain (Check all that apply)?

- ☐ Over-the-counter medications such as Ibuprofen (e.g. Motrin, Advil) or acetaminophen (e.g. Tylenol) or naproxen (e.g. Aleve)
- ☐ Prescription non-steroidal medications (NSAIDS) like ibuprofen (e.g. Motrin) or naproxen (e.g. Naprosyn)
- ☐ Prescription short acting opioid medications like oxycodone (e.g. Roxycodone, Percocet) or hydrocodone (e.g. Lortab or Vicodin), or hydromorphone (e.g. Dilaudid)
- ☐ Prescription long acting opioid medications like long acting oxycodone (e.g.OxyContin), or long acting morphine (e.g.MSContin), fentanyl patch, or methadone
- ☐ Prescription medications for nerve pain, such as gabapentin (e.g. Neurontin), or nortriptyline, or baclofen
- ☐ Prescription or recreational marijuana in any form

How long have you taken these pain medications?

- ○ Less than a week
- ○ More than a week but less than a month
- ○ More than a month

reset

Have you tried to decrease your prescribed pain medication on your own?

○ Yes ○ No ○ Refuse

reset

Has your doctor instructed you on how to reduce your pain medication use?

○ Yes ○ No ○ Refuse

reset

Do you ever experience unwanted side effects from your pain medications that might interfere with your daily activities?

○ Yes ○ No ○ Refuse

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Do you feel that your pain medicines cause side effects (e.g. dizziness, drowsiness, lightheadedness) that might make you fall?

○ Yes ○ No ○ Refuse

reset

Do you ever need early refills for your pain medication?

○ Yes ○ No ○ Refuse

reset

Have you ever gotten enough pain medication to bring your pain to a tolerable level (as prescribed)?

○ Yes ○ No ○ Refuse

reset

Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?

○ Yes ○ No ○ Refuse

reset

Do you ever use pain medications or drugs obtained outside of a medical doctor's directions (e.g. pills taken from friends, or purchased illegally)?

○ Yes ○ No ○ Refuse

reset

Thank you for participating in this study - we are thankful for your help in making care at UCSF better.

If there is anything else you would like to share with us about how your recovery is going, please feel free to type your thoughts below:

Expand

As a reminder - we'll be contacting you again in two weeks to see how things are going. Please let us know if you would like to update your email address or phone numbers, and which you would prefer us to use to contact you:

- ☐ No email change
- ☐ New email
- ☐ No phone number change
- ☐ New phone number

Please provide your new email and/or phone number.

Which do you prefer we use for future surveys?

- ○ Email contact
- ○ Text message with link to survey
- ○ Phone call from study coordinator

reset

Submit

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