Post-Discharge Patient Questionnaire

Thank you for participating in this important study. As you remember, we are asking patients about their physical function, sensitivity to pain, and other factors that may influence recovery after surgery. These factors are definitely underestimated and the best contributors of risk can be shared anyone our research and quality improvement teams.

This survey asks about events (since you left the hospital) in the last 90 days and should take no more than 10 minutes to complete. If you have questions please call Dr. Andrew Auerbach (415-353-7191) or email Hanah Sandy@ucsf.edu.

Form Approved
OMB No. 0920-xxxx
Exp. Date: xx-xx-xxxx

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

Public Reporting burden of this collection of information is estimated at 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Office, 1600 Clifton Road NW, MS D-74, Atlanta, GA 30333; Attn: PRA (0920-xxxx).

Have you seen your primary provider (doctor, nurse practitioner, or physician assistant) in clinic since you left the hospital in the last month?

- Yes
- No
- Don't know

reset

Was this a planned clinic visit or did you need to see your primary doctor because of a problem?

- Planned
- Problem

reset

Have you had any hospitalizations at any hospitals including UCSF since you left the hospital in the last month?

- Yes
- No
- Don't know

reset

Have you had any emergency room visits since you left the hospital in the last month?

- Yes
- No
- Don't know

reset

Have you had any of the following happen in the weeks since you left the hospital in the last month?

	Yes	No
A heart attack	○	○
A stroke or TIA ("mini-stroke")	○	○
A blood clot in your leg or calf	○	○
A blood clot in your lung	○	○
Urinary track infection	○	○
Pneumonia (lung infection)	○	○
A fall	○	○

reset

How many falls have you had since you left the hospital in the last month

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many of these falls led to injury that caused you to limit your activity for at least a day?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many of these falls caused you to see a doctor (or their nurse or physician assistant) in a clinic?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many of these falls caused you to seek care in an emergency room?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many of these falls resulted in hospital stays?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

I would like to ask you some questions about how things have happened since you left the hospital in the last month.

In general, would you say your health since you left the hospital in the last month has been:

- 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 since you left the hospital in the last month? 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

Since you left the hospital in the last month, 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

Since you left the hospital in the last month, 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

Since you left the hospital in the last month, 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 time since you left the hospital in the last month. 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 of xx or 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

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Since you left the hospital in the last month, 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 time since you left the hospital in the last month:

	Yes	No	Don't know/refuse	Not applicable
Do 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 eating food?	○	○	○	○
Did you need help getting in and out the bed and the chair?	○	○	○	○

reset

Thinking about the time since you left the hospital in the last month, 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?	○	○	○	○

reset

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

During your stay in the hospital, who talked to you about your risk of falling? (Only ask during first 14 days post discharge. 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

During your stay in the hospital, who talked to you about medications that might make you fall? (Only ask during the first 14 days post discharge. 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

Since you left the hospital, who 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

During your stay in the hospital (or as part of you discharge instructions), did a healthcare provider recommend any of the following to help your strength and balance or to reduce risk of falling? Check all that apply.

- Physical therapy
- Occupational therapy
- Exercise programs (or yoga or Tai Chi)
- Visiting an eye doctor
- Visiting a foot doctor
- Medication changes
- None

Since you left the hospital, 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

Since you left the hospital, has any health provider recommended any of the following to help your strength, balance, or to reduce risk of falling? Check all that apply.

- Physical therapy
- Occupational therapy
- Exercise programs (or yoga or Tai Chi)
- Visiting an eye doctor
- Visiting a foot doctor
- Medication changes
- None

How many times since you left the hospital have you attended physical therapy sessions to help your strength, balance, or to reduce risk of falling?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many times since you left the hospital have you attended occupational therapy sessions to help your strength, balance, or to reduce risk of falling?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

How many times since you left the hospital have you attended an exercise program to help your strength, balance, or to reduce risk of falling?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4+

reset

Since you visited an eye doctor since you left the hospital to evaluate your vision or reduce your risk of falling?

- Yes
- No
- I plan to

reset

Have you visited a foot doctor since you left the hospital to evaluate your feet or reduce your risk of falling?

- Yes
- No
- I plan to

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 mait beverage, or liquor?

- 0 or less than 1 day/week
- 1 days 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 past week/since you left the hospital 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

reset

In the last 2 weeks, 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

reset

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 medicines like oxycodone (e.g. Roxycodone, Percocet) or hydrocodone (e.g. Lortab or Vicodin), or hydromorphone (e.g. Dilaudid)
- Prescription long acting opioid medicines 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

reset

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

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:

Source!

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