

Study ID: __ __ / __ __ __ __ Patient Initials: _____

headandneck 5000

Questionnaire “About You” – Baseline

Version 3.2

13/05/2013

About You

A1. Date (day/month/year) / /

A2. What is your date of birth? (day/month/year) / /

A3. How tall are you without shoes? ₁ cm OR ₂ feet ₃ inches

A4. What is your current weight? ₁ Kg OR ₂ Stone ₃ lbs

A4a. What was your weight six months ago? ₁ Kg OR ₂ Stone ₃ lbs

A4b. Have you tried to lose weight over the last six months? Yes ₁ No ₂

A4c. Please state your gender: Male ₁ Female ₂

A4d. What is your postcode?

A4e. What is your ethnic group?

- | | |
|--|---|
| <input type="checkbox"/> _{A1} White – British | <input type="checkbox"/> _{J1} Asian – Pakistani or British Pakistani |
| <input type="checkbox"/> _{B1} White – Irish | <input type="checkbox"/> _{K1} Asian – Bangladeshi or British Bangladeshi |
| <input type="checkbox"/> _{C1} White – Other | <input type="checkbox"/> _{L1} Any other Asian background |
| <input type="checkbox"/> _{D1} Mixed – White and Black Caribbean | <input type="checkbox"/> _{M1} Black – Caribbean or British Caribbean |
| <input type="checkbox"/> _{E1} Mixed – White and Black African | <input type="checkbox"/> _{N1} Black – African or British African |
| <input type="checkbox"/> _{F1} Mixed – White and Asian | <input type="checkbox"/> _{P1} Any other Black Background |
| <input type="checkbox"/> _{G1} Any other Mixed background | <input type="checkbox"/> _{R1} Chinese |
| <input type="checkbox"/> _{H1} Asian – Indian or British Indian | <input type="checkbox"/> _{S1} Any other Ethnic group |
| | <input type="checkbox"/> _{Z2} Do not wish to disclose |

A5. Are you currently?

Single <input type="checkbox"/> ₁	Widowed <input type="checkbox"/> ₂	Separated <input type="checkbox"/> ₃
Married <input type="checkbox"/> ₄	Divorced <input type="checkbox"/> ₅	Living with a partner <input type="checkbox"/> ₆

A6. How many years of full-time education did you complete? ₁

A7. What is the highest educational level you obtained?

- Primary school ₁ Secondary school ₂ School or college sixth form ₃
- College of Further Education ₄ Polytechnic or University ₅
- Some other type of college ₆ Please specify: _____ 6A

A8. Are you: a current user of tobacco ₁ or a former user of tobacco ₂
or never used tobacco on a regular basis (1 tobacco product/day for a period of 1 year), ₃

If you have never smoked please tick the box and go to question A13

A9. If you are a former tobacco user, how long ago did you stop using tobacco? ₁ years

A10. At what age did you begin to use tobacco products? ₁ years old

A11. About how much tobacco do you use/did you use on average each day?

- ₁ a) Numbers of cigarettes per day?
- ₁ b) Numbers of hand rolled cigarettes per day?
- ₁ c) Numbers of pipes or cigars per day?
- ₁ d) Number of smokeless tobacco per day?

A12. What brand of cigarettes/tobacco do you/did you normally smoke?

A13. In a typical week how many days do you drink alcohol? Please enter the number of days in the box ₁

If none, tick the box and go to question A17 ₂

A14. Just before you became ill, how many alcoholic drinks did you have each week?

₁ Drinks

A15. About how many bottles of wine, spirits and pints of beers did you drink on average each week?

	a) Bottles of wine	b) Bottles of Spirits	c) Pints of beer/lager/cider
None	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	None <input type="checkbox"/> ₁
Less than 1	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	Less than 7 <input type="checkbox"/> ₂
1	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	7-14 <input type="checkbox"/> ₃
2-3	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	15-21 <input type="checkbox"/> ₄
4-6	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	22-28 <input type="checkbox"/> ₅
7-10	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	28-35 <input type="checkbox"/> ₆
11 or more	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	36 or more <input type="checkbox"/> ₇

A16. What brand of alcohol do you/did you normally drink? _____₁

A17. Are you currently working? Yes ₁ No ₂

A18. If you are currently working, how many hours per week do you work? ₁

A19. What was the occupation/job which you had for the longest time in your life?

A20. Have you ever been unemployed? Yes ₁ No ₂

A21. What is your total household income from all sources before tax & other deductions?

<u>Weekly income before tax</u>	<u>Annual income before tax</u>
Less than £77 <input type="checkbox"/> ₁	Less than £3999 <input type="checkbox"/> ₉
£77 - £154 <input type="checkbox"/> ₂	£4000 - £7999 <input type="checkbox"/> ₁₀
£155 - £230 <input type="checkbox"/> ₃	£8000 - £11999 <input type="checkbox"/> ₁₁
£231 - £346 <input type="checkbox"/> ₄	£12000 - £17999 <input type="checkbox"/> ₁₂
£347 - £442 <input type="checkbox"/> ₅	£18000 - £22999 <input type="checkbox"/> ₁₃
£443 - £558 <input type="checkbox"/> ₆	£23000 - £28999 <input type="checkbox"/> ₁₄
£559 - £673 <input type="checkbox"/> ₇	£29000 - £34999 <input type="checkbox"/> ₁₅
£674 or more <input type="checkbox"/> ₈	£35000 or more <input type="checkbox"/> ₁₆

A22. What proportion of your household income (including your own) would you say comes from benefits?

None ₁ About a quarter ₂ About three quarters ₃
 Very little ₄ About half ₅ All ₆

A23. At present do you have any concerns about any of the following aspects of living with or after cancer?

No <input type="checkbox"/> ₁	Financial concerns <input type="checkbox"/> ₂	Staying in work/college <input type="checkbox"/> ₃
Cost of attending appointments <input type="checkbox"/> ₄	Taking time off work/college <input type="checkbox"/> ₅	Returning to work/college <input type="checkbox"/> ₆

A24. Please tick the box that describes best what you can do:

a) Able to carry out all normal activities without restriction	<input type="checkbox"/> ₁
b) Restricted in physically strenuous activity but able to walk and do light work	<input type="checkbox"/> ₁
c) Able to walk and carry out all self care but unable to carry out any work, up and about more than 50% of waking hours	<input type="checkbox"/> ₁
d) Capable of only limited self care, confined to bed or chair more than 50% of waking hours	<input type="checkbox"/> ₁
e) Completely disabled cannot carry out self care, totally confined to bed or chair	<input type="checkbox"/> ₁

A25. Under each heading, please tick the ONE box that best describes your health today:

a) Mobility

- I have no problems in walking about 1
- I have slight problems in walking about 2
- I have moderate problems in walking about 3
- I have severe problems in walking about 4
- I am unable to walk about 5

b) Self care

- I have no problems washing or dressing myself 1
- I have slight problems washing or dressing myself 2
- I have moderate problems washing or dressing myself 3
- I have severe problems washing or dressing myself 4
- I am unable to wash or dress myself 5

c) Usual activities (e.g. work, study, house work, family or leisure activities)

- I have no problems doing my usual activities 1
- I have slight problems doing my usual activities 2
- I have moderate problems doing my usual activities 3
- I have severe problems doing my usual activities 4
- I am unable to do my usual activities 5

d) Pain discomfort

- I have no pain or discomfort 1
- I have slight pain or discomfort 2
- I have moderate pain or discomfort 3
- I have severe pain or discomfort 4
- I have extreme pain or discomfort 5

e) Anxiety/depression

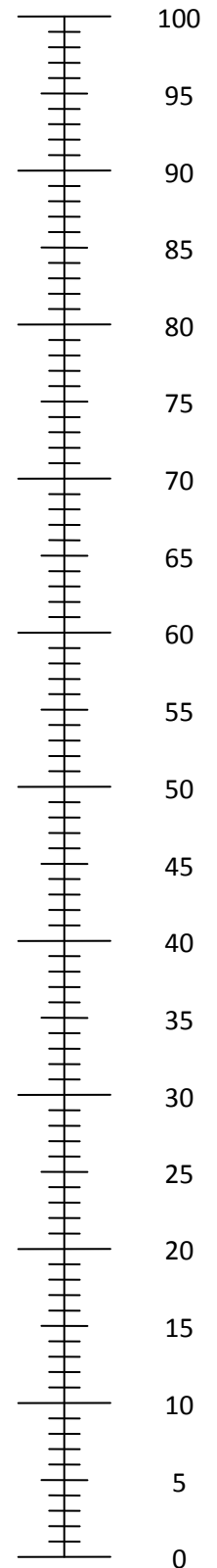
- I am not anxious or depressed 1
- I am slightly anxious or depressed 2
- I am moderately anxious or depressed 3
- I am severely anxious or depressed 4
- I am extremely anxious or depressed 5

The best health
you can imagine

A26.

- We would like to know how good or bad your health is **TODAY**
- This scale is numbered from 0 – 100
- 100 means the best health you can imagine
- 0 means the worst 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 worst health
you can imagine