Patient questionnaire

Getting to know you

This is a questionnaire about your concerns, your worries and what matters to you. Your answers will help us provide the best support and care for you that is catered to your needs and wishes before, during and after your time in hospital.

Your name: .....

Date of birth: .....

Please answer as many questions as you can. This will help us identify any information and support you may need.

1. Who are the most important people in your life?
(How often do you see them and what do you like to do together? This could be partners, family, friends, or pets!)

2. What makes a good day for you?
(What is a good day like, who is it with, what would you do?)

3. When you're having a bad day what makes it better?
(Think about what you and others do that can help if you are having a bad day.)

4. What are the daily or weekly things you enjoy?
(Think about the important activities and routines that you have.)

5. What do you think the people who know you well would say your best qualities are?
(For example, your sense of humour, honesty, kindness and loyal friendship.)

6. Your worries and concerns

Tick any of the following options that are concerns for you:

	Physical concerns
☐	Breathing difficulties
☐	Passing urine
☐	Constipation
☐	Diarrhoea
☐	Eating, appetite and taste
☐	Indigestion
☐	Swallowing
☐	Sore or dry mouth or ulcers
☐	Nausea or vomiting
☐	Tiredness, exhaustion or fatigue
☐	Swelling
☐	High temperature or fever
☐	Moving around (walking/mobility)
☐	Tingling in hands or feet
☐	Pain or discomfort
☐	Dry, itchy or sore skin
☐	Changes in weight
☐	Wound care
☐	Memory or concentration (neurological concerns)
☐	Sight or hearing
☐	Speech or voice problems
☐	My appearance
☐	Sleep problems
☐	Sex, intimacy or fertility
☐	Other medical conditions
☐	Other:

	Practical concerns
☐	Taking care of others
☐	Work or education
☐	Money or finance
☐	Travel
☐	Housing
☐	Transport or parking
☐	Talking or being understood
☐	Laundry or housework

	Grocery shopping
	Washing or dressing
	Preparing meals or drinks
	Pets
	Difficulty making plans
	Smoking cessation
	Problem with alcohol or drugs
	My medication
	Other:

Emotional concerns	
	Uncertainty
	Loss of interest in activities
	Unable to express feelings
	Thinking about the future
	Regret about the past
	Anger or frustration
	Loneliness or isolation
	Sadness or depression
	Hopelessness
	Guilt
	Worry, fear or anxiety
	Independence
	Other:

Family or relationship concerns	
	Partner
	Children
	Other relatives or friends
	Person who looks after me
	Person who I look after
	Communicating with my loved ones
	Other:

Spiritual concerns	
	Faith or spirituality
	Meaning and purpose of life
	Feeling at odds with my culture, beliefs or values
	Other:

Information and support	
	Exercise and activity
	Diet and nutrition
	Complementary therapies
	Physiotherapy
	Planning for my future priorities
	Making a will or legal advice
	Health and wellbeing
	Patient care or support group
	Managing my symptoms
	Advance care planning
	Psychology support services
	Other:

7. Do you have any other questions about your diagnosis or treatments, or the possible side effects?

8. Is there any particular support you feel you may need throughout this treatment?

If you are a patient at one of our hospitals and need this document translated, or in another format such as easy read, large print, Braille or audio, please telephone **0800 484 0135** or email **patientsupporthub@uhs.nhs.uk**

For help preparing for your visit, arranging an interpreter or accessing the hospital, please visit **www.uhs.nhs.uk/additionalsupport**

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