

MyPOS Patient Version



www.pos-pal.org

Patient name:

Date (dd/mm/yyyy):

Patient number: (for staff use)

Please answer the following questions by ticking the box that is most true for you. It is important to answer all of the questions if possible. Your answers will be used to help improve your care and the care of others. Thank you.

Q1. What are your main problems or concerns at the moment?

1.

2.

3.

Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom please tick one box that best describes how it has affected you over the past week.

	No, not at all	Slightly	Moderately	Severely	Overwhelmingly
Pain	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Shortness of breath	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Weakness or lack of energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Nausea (feeling like you are going to be sick)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Vomiting (being sick)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Poor appetite	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Constipation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Sore or dry mouth	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Drowsiness	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Poor mobility	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Diarrhoea	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Tingling in the hands and / or feet	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Difficulty remembering things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Please list any other symptoms not mentioned above, and tick one box to show how they have affected you over the past week.

1.

2.

3.

	<i>No, not at all</i>	<i>Occasionally</i>	<i>Sometimes</i>	<i>Most of the time</i>	<i>Yes, always</i>
Q3. Over the past week, have you been feeling anxious or worried about your illness or treatment?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q4. Over the past week, have any of your family or friends been anxious or worried about you?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q5. Over the past week, have you been feeling depressed?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>Yes, always</i>	<i>Most of the time</i>	<i>Sometimes</i>	<i>Occasionally</i>	<i>No, not at all</i>
Q6. Over the past week, have you felt at peace?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>Yes, as much as I wanted</i>	<i>Most of the time</i>	<i>Sometimes</i>	<i>Occasionally</i>	<i>No, not at all</i>
Q7. Over the past week, have you been able to share how you are feeling with your family or friends?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>Enough information the right amount for me</i>	<i>Information received but hard to understand</i>	<i>Information received but would like more</i>	<i>Very little information and would like more</i>	<i>No information received and would like information</i>
Q8. Over the past week, have you had as much information as you wanted?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>No problems/ Problems addressed</i>	<i>Problems being addressed</i>	<i>Problems partly addressed</i>	<i>Most problems not addressed</i>	<i>Problems not addressed at all</i>
Q9. Over the past week, have any practical matters resulting from your illness been addressed? (such as financial or personal)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Please turn to the next page.

	<i>Yes, as much as I wanted</i>	<i>Most of the time</i>	<i>Sometimes</i>	<i>Occasionally</i>	<i>No, not at all</i>
Q10. Over the past week, have you been able to carry out your usual activities without help from others?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q11. Over the past week, have you been able to pursue your hobbies and leisure activities?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q12. Over the past week, have you been able to spend quality time with family and friends?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

We would like you to answer this question whether or not you are sexually active

Or if you would prefer not to answer then please tick here:

	<i>No, not at all</i>	<i>Occasionally</i>	<i>Sometimes</i>	<i>Most of the time</i>	<i>Yes, always</i>
Q13. Over the past week, have you been worrying about your sex life?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>No, not at all</i>	<i>Occasionally</i>	<i>Sometimes</i>	<i>Most of the time</i>	<i>Yes, always</i>
Q14. Over the past week, have you been worrying about infections?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Q15. Over the past week, have you been worrying about your physical appearance?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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Q16. Over the past week, have you been worrying about your financial situation?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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Q17. Over the past week, have you been worrying that your illness will get worse?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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	<i>Yes, always</i>	<i>Most of the time</i>	<i>Sometimes</i>	<i>Occasionally</i>	<i>No, not at all</i>
Q18. Over the past week, have you felt able to cope with your illness and treatment?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Q19. Are you able to contact your doctors or nurses for advice if needed?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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Q20. Do your doctors and nurses show a good standard of knowledge and skill when treating you?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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Q21. Do your doctors and nurses show care and respect when treating you?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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	<i>Enough information the right amount for me</i>	<i>Information received but hard to understand</i>	<i>Information received but would like more</i>	<i>Very little information and would like more</i>	<i>No information received and would like information</i>
Q22. Do you have enough information about what might happen to you in the future?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>On my own</i>	<i>With help from a friend or relative</i>	<i>With help from a staff member</i>
Q23. How did you complete this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for your time. If you are worried about any of the issues raised on this questionnaire then please speak to your doctor or nurse.