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Questionnaire

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Please complete all questions as fully as you can.

By completing the questionnaire, you are indicating that you agree to participate and are giving your consent for the information you provide to be used in this research study. There is no way that the completed questionnaire can be traced back to you.

Please remember that you don't have to complete this questionnaire (or any question in it) if you don't want to - this is entirely your choice.

SECTION 1: Your feelings about the proposed testing

Please remember that your responses are confidential and your answers will not affect your treatment today

1	In future, if you thought you would get MORE ACCURATE RESULTS by taking a swab your throat (i.e (taking a test using a cotton bud that is wiped to the back of your throat) was also included as part of Chlamydia testing, would you be happy to DO THIS YOURSELF ? (Please tick one box only)				
Yes	<input type="checkbox"/> ₁	No	<input type="checkbox"/> ₂	Unsure	<input type="checkbox"/> ₃
2	If no then please state why (tick as many as apply)				
I worry about taking the sample from the wrong place					<input type="checkbox"/> ₁
I prefer a health care professional to take the sample					<input type="checkbox"/> ₂
I don't want to put any thing in my throat					<input type="checkbox"/> ₃
Other - please tell us your reason (Please write below)					
<hr/>					

Throat sampling



Taking the swab

- Open your mouth wide and wipe the swab around the tonsil area on either side of your throat several times

3	In future, if you thought you would get MORE ACCURATE RESULTS by taking a sample from the entrance to your back passage (anus) was also included as part of Chlamydia testing, would you be happy to DO THIS YOURSELF ? (Please tick one box only)		
	Yes <input type="checkbox"/> ₁	No <input type="checkbox"/> ₂	Unsure <input type="checkbox"/> ₃
4	If no then please state why (tick as many as apply)		
	<p>I worry about taking the sample from the wrong place <input type="checkbox"/> ₁</p> <p>I dont like the idea of touching my own anus <input type="checkbox"/> ₂</p> <p>I prefer a health care professional to take the sample <input type="checkbox"/> ₃</p> <p>I dont want to put any thing in my anus <input type="checkbox"/> ₄</p> <p>Other - please tell us your reason (Please write below)</p> <hr/>		

Anal sampling



Parting buttocks

- Part your buttocks or squat to take the test



Inserting the swab

- Insert the swab 3-4 cm



Taking the swab

- Gently twist the swab and move from side to side

SECTION 2: Information about your sexual history

Please remember that your responses are confidential and this information cannot be used to identify you

5

How many sexual partners have you had in the previous 6 months? Please **tick one box only**

0 ₁ 1 ₂ 2-3 ₃ More than 3 ₄

6

Do you consider yourself to be? Please **tick one box only**

Heterosexual or straight ₁ Gay or Lesbian ₂
Bisexual ₃ Prefer not to say ₄
Prefer to self describe _____ ₅

7

Have you ever had any of these forms of sexual activity? Please **tick all boxes** that apply

Vaginal ₁ Oral ₂
Anal ₃ None of these ₄

8

Do you use condoms as a method of contraception? Please **tick one box only**

Never ₁ Rarely ₂ Mostly ₃ Always ₄

9

What method of contraception do you normally use? Please **tick all boxes** which apply

The Pill ₁ Implant (e.g. Nexplanon) ₂
Male condoms ₃ Contraceptive patch (e.g. Evra) ₄
Copper Coil/intrauterine device ₅ Female condom ₆
Injections (e.g. Depo Provera or Sayana) ₇ Cap/diaphragm ₈
Partner has been sterilised (vasectomy) ₉ I have been sterilised ₁₀
I do not use any method ₁₁
Other method of protection (please say what) _____

10	Have you ever tested positive for an Sexually transmitted infection? Please tick one box only		
Yes <input type="checkbox"/> ₁			No <input type="checkbox"/> ₂
			Unsure <input type="checkbox"/> ₃
11	If you have ever had a positive STI diagnosis? Please tick all boxes which apply		
Chlamydia <input type="checkbox"/> ₁		HIV <input type="checkbox"/> ₂	
Gonorrhoea <input type="checkbox"/> ₃		Herpes <input type="checkbox"/> ₄	
Syphilis <input type="checkbox"/> ₅		Warts <input type="checkbox"/> ₆	
Other (please say what) _____			

SECTION 3: Information about yourself

Please remember that your responses are confidential and this information cannot be used to identify you

12	What age are you (in years)?													
Please write in <input style="width: 80px; height: 25px;" type="text"/>														
13	What are the first five characters of your home postcode? If do you not know your postcode please indicate the area you live e.g. Gorgie (Please write in)													
<table style="margin: auto;"> <tr> <td style="border: 1px solid black; padding: 2px 5px;">E</td> <td style="border: 1px solid black; padding: 2px 5px;">H</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td>e.g. E</td> <td>H</td> <td>1</td> <td>4</td> <td>8</td> </tr> </table>					E	H				e.g. E	H	1	4	8
E	H													
e.g. E	H	1	4	8										
14	Do you smoke? (Please tick one box only)													
Yes <input type="checkbox"/> ₁		No <input type="checkbox"/> ₂		Ex-smoker <input type="checkbox"/> ₃										
15	What is you highest level of education to date? (Please tick one box only)													
No educational qualifications				<input type="checkbox"/> ₁										
Standard grades, intermediate 1 or 2, GCE/GCSEs				<input type="checkbox"/> ₂										
Higher, Advance Higher, A Levels				<input type="checkbox"/> ₃										
Vocational qualification (e.g. Access, SVQ, SCOTVEC, BTEC)				<input type="checkbox"/> ₄										
Higher National Certificate (HNC)/ Diploma (HND)				<input type="checkbox"/> ₅										

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Which of the following best describes your ethnic background?
(Please tick **one box only**)

White (Scottish, British, Irish or any other White background)

 1

Asian or Asian British (Bangladeshi, Indian, Pakistani or any other Asian background)

 2

Black or Black British (African, Caribbean or any other Black background)

 3

Chinese or Chinese British

 4

Mixed or any other ethnic background (Please write in below)

 5

You have now reached the end of the questionnaire.
Please place the questionnaire in the box at reception

If you wish to be contacted as part of the interview part
of the study please fill in the form on the next page

Many thanks for your time and help

SECTION 4: Consent for interview

Please remember that participation is voluntary and you do not need to provide your contact details unless you wish to take part in the interview part of the study

Contact Details for Interview:

First name Surname.....

Telephone number

Email

Address (Number, street)

City Postcode

I prefer to be contacted by (please tick):

PHONE EMAIL POST

ANY OF ABOVE

I prefer to be contacted (please tick all that apply):

	Any time	Morning (9am-12 noon)	Afternoon (12 noon-5pm)	Evening (5-8pm)
Weekday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other specific instructions:				

Please detach this sheet, seal it in the envelope provided and hand it in to reception