|  |
| --- |
| **CRF 03: RUTI Trial: Recurrent Urinary Tract Infection Trial** |
| **Date** **d d m m y y y y** | **Researcher ID** | **Site ID** | **Patient ID** |

**RUTI Trial Diary **

**CRF 03**

**Instructions for completing the diary:**

**As part of the study you have consented to take part in, we would like you to complete this diary. It is divided into 3 sections as below:**

1. Section 1: Please complete **on the day** you see your practitioner/practice nurse
2. Section 2 : This section is to be completed **daily whenever you have symptoms of a urinary tract infection** over the next 16 weeks
3. Section 3 is to be completed at the **end of the trial and returned to your practitioner/practice nurse or in the prepaid envelope provided.**

When you have completed sections sections 1 (at the beginning of the trial) and 3 (at the end of the trial) please return them to your practice nurse/practitioner.

Section 2 is for you to take home and to complete if/when you have an infection. Please keep these forms safely and hand them in to your practice nurse/practitioner. Alternatively you can return these forms via e mail to Andrew.Flower@soton.ac.uk

If you lose or misplace Section 2 please contact us as soon as possible and we will provide you with a replacement form.

**Section 1: About You (Complete on the day you see the practice nurse or CHM practitioner)**

**A. Date of birth:**  / /

 d d / m m / y y y y

**B. History of Urinary tract Infections (UTI)?**

**1. Have you had a urinary tract infection (UTI), diagnosed by a doctor and confirmed with a urine culture in the past 12 months**

**Yes No**

**2. How many times have had a UTI in the past year?**

 **3 – 5**

 **6-9**

 **more than 10**

 **continuous symptoms of infection**

**3. Roughly, how many months apart are your UTIs?**

**4. How many years have you been suffering from recurrent UTIs**

**1 - 2**

**3 - 4**

**5 -9**

**more than 9 years**

**5. How was your last UTI treated?**

 **Antibiotics Name of antibiotic (if known) ...................................**

**Other Please specify ..................................................................................**

**Don’t remember**

**No Treatment**

**6. Have you ever used Chinese herbal medicine before?**

**Yes No**

**7. Please indicate if you regularly experience any of the following symptoms when you have a urinary tract infection and circle the number that shows how severe they are (Please circle one number for each symptom).**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms | Do not have | Mild | Moderate | Severe |
| Urgency of urination (a strong anduncontrollable urge to pass urine) | 0 | 1 | 2 | 3 |
| Pain or burning when passing urine | 0 | 1 | 2 | 3 |
| Frequency of urination (going to thetoilet very often)  | 0 | 1 | 2 | 3 |
| Not being able to empty your bladdercompletely/passing only smallamounts of urine | 0 | 1 | 2 | 3 |
| Pain or uncomfortable pressure in thelower abdomen caused byyour urinary tract infection | 0 | 1 | 2 | 3 |
| Low back pain caused by your urinarytract infection | 0 | 1 | 2 | 3 |
| Blood in your urine | 0 | 1 | 2 | 3 |

**8. Are you involved in a sexually active relationship?**

**Yes No**

**9. Have you gone through the menopause?**

 **Yes No**

**10. Please describe any other common symptoms you experience during a UTI that we have not already mentioned?**

**C. Under each heading, please tick the ONE box that best describes your health TODAY**

**Mobility**

 **I have no problems in walking about**

 **I have slight problems in walking about**

 **I have moderate problems in walking about**

 **I have severe problems in walking about**

 **I am unable to walk about**

**Self-care**

 **I have no problems washing or dressing myself**

 **I have slight problems washing or dressing myself**

 **I have moderate problems washing or dressing myself**

 **I have severe problems washing or dressing myself**

 **I am unable to wash or dress myself**

**Usual Activities** (e.g. work, study, housework, family or leisure activities)

 **I have no problems doing my usual activities**

 **I have slight problems doing my usual activities**

 **I have moderate problems doing my usual activities**

 **I have severe problems doing my usual activities**

 **I am unable to do my usual activities**

**Pain / Discomfort**

 **I have no pain or discomfort**

 **I have slight pain or discomfort**

 **I have moderate pain or discomfort**

 **I have severe pain or discomfort**

 **I have extreme pain or discomfort**

**Anxiety / Depression**

 **I am not anxious or depressed**

 **I am slightly anxious or depressed**

 **I am moderately anxious or depressed**

 **I am severely anxious or depressed**

 **I am extremely anxious or depressed**

* **We would like to know how good or bad your health is TODAY**

10

0

20

30

40

50

60

80

70

90

100

5

15

25

35

45

55

75

65

85

95

The best health
 you can imagine

The worst health
 you can imagine

* **This scale is numbered from 0 to 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 =**

**Section 2: Diary of UTI symptoms-to be completed at home whenever you have a urinary tract infection during the trial**

Please fill in the diary on the following page by completing the appropriate answer, EACH EVENING (starting when you first experience symptoms of a urinary tract infection), about how you have felt during the last 24 hours. When you no longer have symptoms, please enter ‘0’.

For medications, please enter the details of any medication prescribed for your UTI and any other medications you may be taking. Other medications can also include other herbal remedies, such as Cranberry juice, other fruit juice, bicarbonate solution, potassium citrate, Uvacin, Cantharis.

**For each symptom rate how bad it is on the following scale:**

**0 = Normal/not affected**

**1 = Very little problem**

**2 = Slight problem**

**3 = Moderately bad**

**4 = Bad**

**5 = Very bad**

**6 = As bad as it could be**

**In the diary the first column is an example of how a day would be completed if it was a Monday and you had very bad burning, slight urgency, daytime frequency and night-time frequency, very little restriction in activities, and no other symptoms.**

**In addition there is an example of how you would complete the medication section of the diary if you were prescribed Trimethoprim 20omg twice a day, and took two doses per day for a week, every day except the first day when you only took one dose.**

**PLEASE COMPLETE THE DIARY FOR YOUR UTI STARTING FROM COLUMN 1**

**EACH TIME YOU HAVE A NEW EPISODE OF A UTI PLEASE USE A DIFFERENT DIARY SHEET**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 **Diary**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day** | **Example** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **Date** | 08/12/13 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Day of the week** | *M* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood in Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burning | *5* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urgency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daytime Frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Night time frequency | *2* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Smelly Urine | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tummy Pain | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restricted Activities | *1* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unwell | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Work Loss | *0* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medications taken for your UTI** | **Strength of each dose** (e.g. 200 mg) | **Doses per day** | **Number of doses taken each day** |
| *E.g. Trimethoprim* | *200mg* | *2* | *1* | *2* | *2* | *2* | *2* | *2* | *2* | *0* | *0* | *0* | *0* | *0* | *0* | *0* |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Healthcare consultations –** please place a tick in the box for each day you consulted with a healthcare professional about your UTI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Section 3. RUTI Trial Monthly Diary**

We have identified some of the activities that are commonly affected by Recurrent Urinary Tract Infections (RUTIs). Please only complete the diary for activities that relate to you (e.g. if you do not work then just leave this square blank). There is an empty box at the bottom of the first column that you can use if you wish to add one regular activity that you do which is affected by your RUTIs.

**Please complete this diary at the beginning of the trial and at the end of each month.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** |  |  |  |  |  |  |  |
| **Please indicate how many days this month that you have been unable to do the following activities because of your UTIs.** | **Month O (beginning)**  | **Month 1** | **Month 2** | **Month 3** | **Month 4** | **Month 5** | **Month 6** |
| **Go to work (days)** |  |  |  |  |  |  |  |
| **Go out to socialise (days)** |  |  |  |  |  |  |  |
| **Participate in exercise** |  |  |  |  |  |  |  |
| **Go out to the shops** |  |  |  |  |  |  |  |
| **Have sexual relations with your partner** |  |  |  |  |  |  |  |
| **Participate in your chosen hobby** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**1. With respect to your urinary symptoms please mark how they have changed in the past month?**

 -50 -40 -30 -20 -10 0 +10 +20 +30 +40 +50

 :...:....:....:....:....:....:....:....:....:....:....:....:...:....:....:....:....:....:....:.....:..:.....:….

Completely recovered

No Change

Much

 worse

**2. Please mark the number of urinary tract infections you have had in the past month?**

 0 1 2 3 or more continuous symptoms

**3. Please mark on the scale how easy you have found it to take your herbal medicine.**

 -50 -40 -30 -20 -10 0 +10 +20 +30 +40 +50

 :...:....:....:....:....:....:....:....:....:....:....:....:...:....:....:....:....:....:....:.....:....:.....:....

Extremely easy

Extremely difficult

**4. Please write below any comments you would to make about how you find taking Chinese herbal medicine.**

**Section 4: Health Outcomes-to be completed at the end of the trial.**

The following questions are the same as those you answered in Section 1E. We would like you to answer them again at the end of the trial to see if anything has changed.

**Under each heading, please tick the ONE box that best describes your health TODAY**

**Mobility**

 **I have no problems in walking about**

 **I have slight problems in walking about**

 **I have moderate problems in walking about**

 **I have severe problems in walking about**

 **I am unable to walk about**

**Self-care**

 **I have no problems washing or dressing myself**

 **I have slight problems washing or dressing myself**

 **I have moderate problems washing or dressing myself**

 **I have severe problems washing or dressing myself**

 **I am unable to wash or dress myself**

**Usual Activities** (e.g. work, study, housework, family or leisure activities)

 **I have no problems doing my usual activities**

 **I have slight problems doing my usual activities**

 **I have moderate problems doing my usual activities**

 **I have severe problems doing my usual activities**

 **I am unable to do my usual activities**

**Pain / Discomfort**

 **I have no pain or discomfort**

 **I have slight pain or discomfort**

 **I have moderate pain or discomfort**

 **I have severe pain or discomfort**

 **I have extreme pain or discomfort**

**Anxiety / Depression**

 **I am not anxious or depressed**

 **I am slightly anxious or depressed**

 **I am moderately anxious or depressed**

 **I am severely anxious or depressed**

**I am extremely anxious or depressed**

* **We would like to know how good or bad your health is TODAY**

10

0

20

30

40

50

60

80

70

90

100

5

15

25

35

45

55

75

65

85

95

The best health
 you can imagine

The worst health
 you can imagine

* **This scale is numbered from 0 to 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 =**

**Please indicate if you regularly experience any of the following symptoms when you have a urinary tract infection and circle the number that shows how severe they are (Please circle one number for each symptom).**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms | Do not have | Mild | Moderate | Severe |
| Urgency of urination (a strong anduncontrollable urge to pass urine) | 0 | 1 | 2 | 3 |
| Pain or burning when passing urine | 0 | 1 | 2 | 3 |
| Frequency of urination (going to thetoilet very often)  | 0 | 1 | 2 | 3 |
| Not being able to empty your bladdercompletely/passing only smallamounts of urine | 0 | 1 | 2 | 3 |
| Pain or uncomfortable pressure in thelower abdomen caused byyour urinary tract infection | 0 | 1 | 2 | 3 |
| Low back pain caused by your urinarytract infection | 0 | 1 | 2 | 3 |
| Blood in your urine | 0 | 1 | 2 | 3 |

|  |  |  |
| --- | --- | --- |
| 1. Which treatment group do you feel you have been part of?
 |  | Active |
|  | Placebo |
| 1. How certain are you of your answer?
 |  | Not at all sure, just guessed |
|  | Fairly sure |
|  | Entirely sure |
| 1. What makes you think you have been allocated to this treatment group? Please provide as much information as you would like.
 |
|  |

**Thank you for completing this questionnaire and diary.**

**The information you have provided will remain anonymous but the pooled data will help us to improve our management of patients with UTI.**

**Please return this questionnaire/diary to :**

**Freepost RTLE-TKTU-KRBX**

**RUTI Trial Manager,**

**Aldermoor Health Centre, Aldermoor Close , Southampton SO16 5ST**