

# IPOS-Renal Patient Version



www.pos-pal.org

Patient name : .....  
 Date (dd/mm/yyyy) : .....  
 Patient number : ..... (for staff use)

## Q1. What have been your main problems or concerns over the past week??

1. ....
2. ....
3. ....

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

	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"/>
Itching	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Difficulty Sleeping	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Restless legs or difficulty keeping legs still	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Changes in skin	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"/>

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

1. ....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. ....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. ....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

**Over the past week:**

	Not at all	Occasionally	Sometimes	Most of the time	Always
Q3. 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. 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. 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"/>

	Always	Most of the time	Sometimes	Occasionally	Not at all
Q6. 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"/>
Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q8. 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"/>

	Problems addressed/ No problems	Problems mostly addressed	Problems partly addressed	Problems hardly addressed	Problems not addressed
Q9. Have any practical problems 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"/>

	None at all	Up to half a day wasted	More than half a day wasted
Q10. How much time do you feel has been wasted on appointments relating to your healthcare, e.g. waiting around for transport or repeating tests	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

	On my own	With help from a friend or relative	With help from a member of staff
Q11. How did you complete this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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