BUMPES

A study of position during the late stages of labour in women with an epidural

Woman's study number:

You and your first child's health at one year

You may remember that you agreed to take part in a research study looking at different positions for labour.

As part of that research, we would, through this questionnaire, like to find out about your health and your child's health now that your baby is around one year old.

We realise that you may be very busy at this time, but we would be very grateful if you could spare the time to fill in this questionnaire as the information you provide is very important to the study. All information will be treated in the strictest confidence.

Please answer ALL questions.

Please send the questionnaire back to us in the pre-paid envelope.

If you would like to know more about BUMPES or need help completing this questionnaire, please contact us by telephone or e-mail at:

BUMPES Co-ordinating Centre

Clinical Trials Unit, BUMPES Study, UCL
Gower Street, London, WC1E 6BT

Telephone: 0207 679 0939
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Section 1: Your health today

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

1.1 Mobility

- I have no problems in walking about ☐
- I have some problems in walking about ☐
- I am confined to bed ☐

1.2 Self-Care

- I have no problems with self-care ☐
- I have some problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

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

- I have no problems with performing my usual activities ☐
- I have some problems with performing my usual activities ☐
- I am unable to perform my usual activities ☐

1.4 Pain/Discomfort

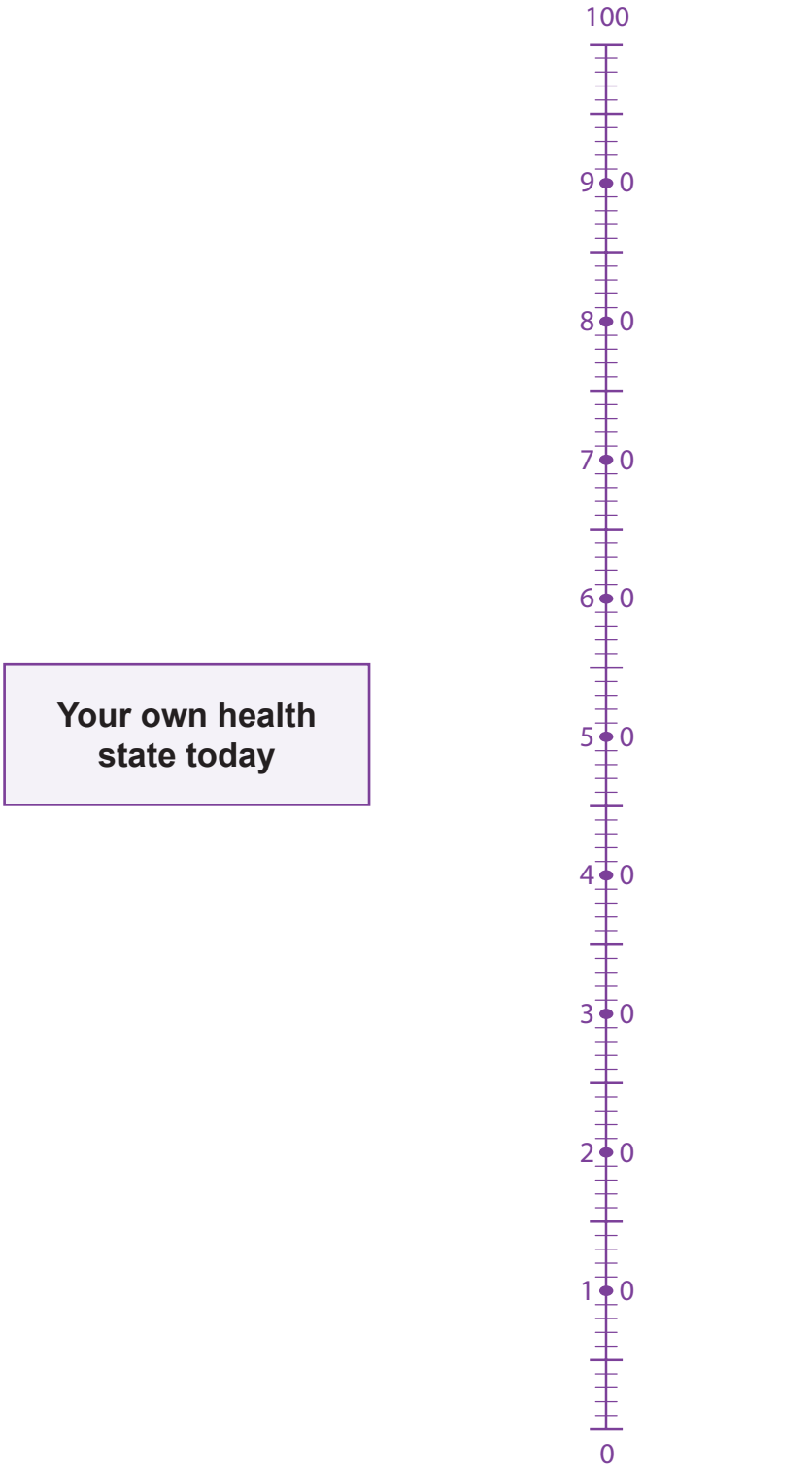
- I have no pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have extreme pain or discomfort ☐

1.5 Anxiety/Depression

- I am not anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am extremely anxious or depressed ☐

1.6 **To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.**
We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Best imaginable health state



Worst imaginable health state

Section 2: Your health and well-being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

For each of the following questions, please tick the one box that best describes your answer.

2.1 In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2.2 The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
Climbing several flights of stairs	☐	☐	☐

2.3 During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Accomplished less than you would like	☐	☐	☐	☐	☐
Were limited in the kind of work or other activities	☐	☐	☐	☐	☐

2.4 During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Accomplished less than you would like	☐	☐	☐	☐	☐
Did work or other activities less carefully than usual	☐	☐	☐	☐	☐

2.5 During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

2.6 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐
Have you felt downhearted and low?	☐	☐	☐	☐	☐

2.7 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Section 3: Your health following the birth of your first child

3.1 Have you had another baby since the birth of your first child? Yes ☐ No ☐

3.2 Are you currently pregnant? Yes ☐ No ☐

Childbirth can result in some women experiencing problems when passing urine, with bowel control or experiencing pain during sexual intercourse. When we look at the results of the BUMPES study, we want to know whether different positions in labour affect any of these possible problems.

Many people leak urine some of the time and this can occur in some women after the birth of a child. We are trying to find out how many women leak urine and how much this bothers them.

3.3 Did you have any leaking of urine in the first three months after the birth of your first child? Yes ☐ No ☐

We would be grateful if you could answer the following questions on this page, thinking about how you have been, on average, over the **past 4 weeks**.

3.4 How often do you leak urine? *(Tick one box)*

- ☐ Never
- ☐ About once a week or less often
- ☐ Two or three times a week
- ☐ About once a day
- ☐ Several times a day
- ☐ All the time

3.5 We would like to know how much urine you think leaks.
How much urine do you usually leak (whether you wear protection or not)? *(Tick one box)*

- ☐ None
- ☐ A small amount
- ☐ A moderate amount
- ☐ A large amount

3.6 Overall, how much does leaking urine interfere with your everyday life?

Please ring a number between 0 (*not at all*) and 10 (*a great deal*)

0 1 2 3 4 5 6 7 8 9 **10**

not at all *a great deal*

3.7 When does urine leak? *(Please tick all that apply to you)*

- ☐ Never – urine does not leak
- ☐ Leaks before you can get to the toilet
- ☐ Leaks when you cough or sneeze
- ☐ Leaks when you are asleep
- ☐ Leaks when you are physically active/exercising
- ☐ Leaks when you have finished urinating and are dressed
- ☐ Leaks for no obvious reason
- ☐ Leaks all the time

The next few questions ask about some other health problems/symptoms that women sometimes have after giving birth.

3.8 Since the birth of your first child, have you had any of the following bowel control problems? *(Please tick all that apply)*

a) No bowel control at times:

- ☐ Never
- ☐ In the first 3 months
- ☐ In the past 4 weeks
- ☐ At any other time

b) Soiling from your back passage on your underwear:

- ☐ Never
- ☐ In the first 3 months
- ☐ In the past 4 weeks
- ☐ At any other time

c) Feel the need to go and have to go immediately:

- ☐ Never
- ☐ In the first 3 months
- ☐ In the past 4 weeks
- ☐ At any other time

3.9 Since the birth of your first child, have you had constipation?

- ☐ Never
- ☐ In the first 3 months
- ☐ In the past 4 weeks
- ☐ At any other time

3.10 Since the birth of your first child, have you had haemorrhoids (sometimes called piles)?

- ☐ Never
- ☐ In the first 3 months
- ☐ In the past 4 weeks
- ☐ At any other time

3.11 Since the birth of your first child, have you had pain when you have sexual intercourse?

- ☐ Never
- ☐ In the first 3 months
- ☐ In the past 4 weeks
- ☐ At any other time
- ☐ Not had sexual intercourse since the birth

Section 4: Hospital visits for you

The following section asks about your use of hospital services **following discharge home from hospital after the birth of your first child**. *Please answer all questions as fully as possible.*

4.1 Have you been admitted to hospital in the past year? Yes ☐ No ☐

If Yes, please provide details for each individual visit. *(If more than 4 visits use the back page)*

Hospital admission 1:

Reason _____

Did you stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you stayed in hospital ☐☐

Did you have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you had _____

_____

Hospital admission 2:

Reason _____

Did you stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you stayed in hospital ☐☐

Did you have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you had _____

_____

Hospital admission 3:

Reason _____

Did you stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you stayed in hospital ☐☐

Did you have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you had _____

_____

Hospital admission 4:

Reason _____

Did you stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you stayed in hospital ☐☐

Did you have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you had _____

_____

4.2 **Have you attended an outpatient clinic in a hospital for your health since the birth of your first child?** Yes ☐ No ☐

If Yes, please provide details for each individual visit. *(Please do not include visits to antenatal clinics)*

Type of clinic	**Attended** *(please tick)*	**Number of times**	**Reason**
Perineal care clinic	Yes ☐	☐☐	
Gynaecological	Yes ☐	☐☐	
Surgical	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	

Section 5: Your first child's health

The following question asks about your first child's use of hospital services **following discharge home from hospital after birth**. Please answer all questions as accurately as possible.

5.1 Has your first child been admitted to hospital in the past year? Yes ☐ No ☐

If Yes, please provide details for each individual visit. *(If more than 4 visits use the back page)*

Hospital admission 1:

Reason _____

Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital ☐☐

Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had _____

_____

Hospital admission 2:

Reason _____

Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital ☐☐

Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had _____

_____

Hospital admission 3:

Reason _____

Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital ☐☐

Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had _____

_____

Hospital admission 4:

Reason _____

Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital ☐☐

Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had _____

_____

5.2 Has your first child attended an outpatient clinic in the last year? Yes ☐ No ☐

If Yes, please provide details for each individual visit.

Type of clinic	Attended *(please tick)*	Number of times	Reason
Orthopaedic	Yes ☐	☐☐	
Paediatric	Yes ☐	☐☐	
Hearing	Yes ☐	☐☐	
Eye	Yes ☐	☐☐	
Dermatology	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	
Other *please specify* _____ _____	Yes ☐	☐☐	

The following questions ask about your child's development. You might find it helpful to refer to the red book (Child Health Record) and comments made by your health visitor and doctor.

5.3 Has your first child been diagnosed with cerebral palsy? Yes ☐ No ☐

5.4 Has your first child been diagnosed with any other major health problem? Yes ☐ No ☐

If Yes, please specify: _____

_____

Date this form completed: D D / M M / Y Y

Your date of birth: D D / M M / Y Y

Thank you for completing this questionnaire

Please return it to us in the FREEPOST envelope provided. No stamp is required.

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