

Healthcare Usage Questionnaire



We would like to know how much use you have made of the health and social services over the last 3/6 months. If you are not exactly sure, we would rather have your best guess than no information at all.

Please answer every question, even if the answer is 'No'.

1. Over the last 3 / 6 months, if, and how many times, you have:

Type of service	No	Yes	If yes: Number of visits
a. i Been seen by a GP at home ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
a. ii Been seen by a GP in the surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. i Been seen by a practice nurse at home ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. ii Been seen by a practice nurse in the surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Been seen by a Parkinson's Disease Nurse Specialist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Been seen by a health visitor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Been seen by a social worker?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Been seen by a physiotherapist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. Been seen by an occupational therapist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. Been seen by a speech or language therapist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. Consulted a private practitioner such as an acupuncturist	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. Over the last 3 / 6 months have you been to hospital for any reason?

Type of visits	No	Yes	If Yes: number of days of attendance	Reason for Admission
a. NHS hospital Out-patient clinic	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	
b. NHS hospital inpatient	<input type="checkbox"/>	<input type="checkbox"/>	Number of nights:	
c. NHS Accident and Emergency Department	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	
d. Private hospital out-patient clinic	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	
e. Private hospital inpatient	<input type="checkbox"/>	<input type="checkbox"/>	Number of nights:	
f. Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>		

3. Over the last 3 / 6 months, have you suffered from a fall that resulted in injury and/or medical attention?

No

Yes, please give details: _____

Date of fall:...../...../.....

Did you see your GP? No Yes

Were you seen by Ambulance Staff? No Yes

Did you go to hospital? No Yes

If yes, which hospital? _____

How many nights did you stay in hospital? _____

4a. Are you currently in paid employment?

No (please go to question 4c) Yes (please go to question 4b)

4b. If yes, due to your Parkinson's disease have you had to reduce the number of hours per week you work over the last 3 / 6 months? (Please tick only one).

No, I work the same hours. Please state how many hours this is:.....

Yes, I have had to reduce my working hours by.....hours per week.

Yes, I have had to stop work completely.

4c. In the last 3 / 6 months have you had to stop work completely due to your Parkinson's disease?

No Yes

If you are not employed: due to your Parkinson's disease, in the last 3 / 6 months have you had to reduce the number of hours per week you spend carrying out your normal daily activities?

No

Yes, I have had to reduce my normal daily activities (e.g. gardening, housework, social activity) by.....hours per week.

5. Over the last 3 / 6 weeks has a relative or friend taken time off work to look after you?

No

Yes, how many days.....

Yes, had to stop work completely.

6. In the last 3 / 6 months did you make regular use of the following?

Name of service	No	Yes	If yes: Number of times on average per week?
a. Home care/home help	<input type="checkbox"/>	<input type="checkbox"/>	How many home visits?
b. Meals on wheels	<input type="checkbox"/>	<input type="checkbox"/>	How many meals?
c. Day centre	<input type="checkbox"/>	<input type="checkbox"/>	How many days?
d. Luncheon Club	<input type="checkbox"/>	<input type="checkbox"/>	How many meals?
e. Sitting Service	<input type="checkbox"/>	<input type="checkbox"/>	How many days?
f. Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	How many home visits?

7. Have you moved into institutional care (i.e. a residential or nursing home)?

No

Yes, date admitted (month/ year): _____

Type of home: Nursing Residential

Address of Home _____

8 In the last 3 / 6 months did you buy any aid or adaptation paid for by yourself or by a friends or relative? (E.g. walking frames, grab bars, stair lift, wheel chair)

Type of aid or adaptations	Cost to you (£'s)
a	
b	
c	
d	

9. During the last 3 / 6 months, approximately how much additional money have you spent on travel (E.g. taxis, car park fees and public transport) because of your Parkinson's disease?

None

Yes, I have spent £ _____

10. Do you have to pay for your Parkinson's disease medication?

No

Yes, I have spent £ _____ per month

11. Do you receive benefits?

No

Yes, if so are they: Low Medium High

12. If you would like to tell us about any other costs incurred because of your Parkinson's disease over the last 3 / 6 months, please write them here

None

Yes, please give details: _____