Side-effect Questionnaire

Name: ____________________________________________
ID: _____________________________________________
Day of treatment: __________________________________
Treatment nr: ______  Dwell-time: __________ minutes

1. How often did you have to void after treatment (frequency)?
   □ Normal
   □ More than normal
   □ Every other hour
   □ Once every hour
   □ Several times every hour

2. When were your voiding normally again?
   □ Normal all the time
   □ In six hours
   □ In twelve hours
   □ In twenty-four hours
   □ Two days later
   □ Three days later
   □ More than three days later

3. Chills?
   □ No
   □ Yes

4. Fever?
   □ No
   □ Yes  Temperature: ______ °C

5. Nausea?
   □ No
   □ Yes
6. Dysuria?
☐ No
☐ Yes If yes, for how long?
☐ About six hours
☐ About twelve hours
☐ About twenty-four hours
☐ For two days
☐ For three days
☐ More than three days later

7. Haematuria?
☐ No
☐ Yes For how many days: _____

8. When were you back to normal after the treatment?
☐ After six hours
☐ After twelve hours
☐ After twenty-four hours
☐ After two days
☐ After three days
☐ After more than three days

9. Any other symptoms that you would like to discuss?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________