**Tube symptoms questionnaire:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Never | Occasional | Frequent | Always |
| How often do you feel discomfort or pain related to your tube? |  |  |  |  |
| How often do you need pain killers due to pain or discomfort related to your tube? |  |  |  |  |
| How often do you experience urination discomfort or pain? |  |  |  |  |
| How often do you experience blood in your urine? |  |  |  |  |
| How often do you experience personal hygiene problems due to your tube? |  |  |  |  |
| How often do feel that moving around is associated with discomfort? |  |  |  |  |