

Participant ID			

Date							
D	D	M	M	Y	Y	Y	Y



Question set instructions

This survey is designed to collect information about you.

Why are we asking these questions?

Your answers are key to understanding who is in our research. This will help us to see who is not taking part. We can then design our studies to better include and benefit everyone.

We have worked with patients and members of the public to carefully select these questions from UK national surveys (e.g. the census).

Please respond to as many questions as you feel comfortable. Your answers will remain confidential and will not affect your care. If you would rather not answer any question, please select “prefer not to say”.

1. Gender

Which of the following best describes your gender?

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Man

Non-binary

Prefer not to say

<input type="checkbox"/>
<input type="checkbox"/>

Woman

Prefer to self-describe (specify, if you wish)

2. Do you consider yourself to be trans?

Trans is a term used to describe people whose gender is not the same as the sex they were registered at birth.

<input type="checkbox"/>
<input type="checkbox"/>

Yes

No

<input type="checkbox"/>

Prefer not to say



3. Which of the following best describes your sexual orientation?

This is not a complete list. Please choose the option that best fits you.

<input type="checkbox"/>	Bisexual	<input type="checkbox"/>	Straight or Heterosexual
<input type="checkbox"/>	Gay or Lesbian	<input type="checkbox"/>	Prefer to self-describe (specify, if you wish)
<input type="checkbox"/>	Prefer not to say		

4. What is your religion?

<input type="checkbox"/>	No religion
<input type="checkbox"/>	Buddhism
<input type="checkbox"/>	Christianity (including Church of England, Catholic, Protestant and all other Christian denominations)
<input type="checkbox"/>	Hinduism
<input type="checkbox"/>	Islam
<input type="checkbox"/>	Judaism
<input type="checkbox"/>	Sikhism
<input type="checkbox"/>	Any other religion, (specify, if you wish):
<input type="checkbox"/>	
<input type="checkbox"/>	Prefer not to say

5. What is your preferred language?

<input type="checkbox"/>	English
<input type="checkbox"/>	Other, (specify, if you wish):
<input type="checkbox"/>	
<input type="checkbox"/>	Prefer not to say



6. Do you consider yourself to have a disability?

A disability is a physical or mental condition that has a 'substantial' and 'long-term' impact on your ability to do normal daily activities.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Prefer not to say		

7. Other than your bronchiectasis diagnosis, do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know	<input type="checkbox"/>	Prefer not to say

8. Do any of these conditions or illnesses affect you in any of the following areas?

<input type="checkbox"/>	Vision (e.g. blindness or partial sight)
<input type="checkbox"/>	Hearing (e.g. deafness or partial hearing)
<input type="checkbox"/>	Mobility (e.g. walking short distances or climbing stairs)
<input type="checkbox"/>	Dexterity (e.g. lifting and carrying objects or using a keyboard)
<input type="checkbox"/>	Learning or understanding or concentrating
<input type="checkbox"/>	Memory
<input type="checkbox"/>	Mental Health
<input type="checkbox"/>	Stamina or breathing or fatigue
<input type="checkbox"/>	Socially or behaviourally (e.g. understanding social cues or nonverbal skills)
<input type="checkbox"/>	Other
<input type="checkbox"/>	None of the above
<input type="checkbox"/>	Prefer not to say



9. Have you completed any qualifications?

If you did not complete your education in the UK, please choose the closest equivalent. This is not a complete list. Please choose the options that best fit you.

Please select all that apply:

- | | |
|--------------------------|---|
| <input type="checkbox"/> | No formal qualifications |
| <input type="checkbox"/> | GCSEs or equivalent (e.g. GCSEs, O levels, CSEs, Basic Skills course) |
| <input type="checkbox"/> | AS, A level or equivalent |
| <input type="checkbox"/> | NVQ up to level 3 or equivalent (e.g. NVQ level 1-3, BTEC General or National, OND or ONC, City and Guilds Advanced Craft) |
| <input type="checkbox"/> | Qualification at degree level or above (e.g. university degree, foundation degree, HND, HNC, NVQ level 4 or above, teaching or nursing) |
| <input type="checkbox"/> | Apprenticeship (e.g. trade, advanced, foundation, modern) |
| <input type="checkbox"/> | Any other qualifications or equivalent unknown |
| <input type="checkbox"/> | Prefer not to say |

10. Employment

Please select all that apply:

- | | | | |
|--------------------------|------------------------------------|--------------------------|--|
| <input type="checkbox"/> | Employed (including self-employed) | <input type="checkbox"/> | On temporary leave (e.g. parental leave) |
| <input type="checkbox"/> | Not employed | <input type="checkbox"/> | Studying |
| <input type="checkbox"/> | Retired | <input type="checkbox"/> | Prefer not to say |



11. Caring responsibilities

Do you have a caring responsibility for a child/children under the age of 16?

Yes

No

Prefer not to say

12. Are you the main carer for anyone because they have long-term physical or mental health conditions or illnesses?

Yes

No

Prefer not to say