

QUALITY OF LIFE QUESTIONNAIRE

QOL

Patient ID: 1 _____
 Patient Initials: _____
 Visit Number: _____
 Visit Date: ____/____/____
month day year
 Interviewer ID: _____

(Patient completed)

Please tell us how much you have been limited by your asthma during the last 2 weeks in each of your 5 most important activities. Refer to the Quality of Life Activities form (QOLACT) for your list of activities. If you have not done the activity in the last 2 weeks, leave the question blank.

HOW LIMITED HAVE YOU BEEN DURING THE LAST 2 WEEKS IN THESE ACTIVITIES?

		Not at all Limited	A Little Limitation	Some Limitation	Moderate Limitation	Very Limited	Extremely Limited	Totally Limited
01	1. <u>Activity 1</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
02	2. <u>Activity 2</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
03	3. <u>Activity 3</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
04	4. <u>Activity 4</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
05	5. <u>Activity 5</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
06	6. How much discomfort or distress have you felt over the last 2 weeks as a result of CHEST TIGHTNESS?	None <input type="checkbox"/> ₁	Very Little <input type="checkbox"/> ₂	Some <input type="checkbox"/> ₃	Moderate Amount <input type="checkbox"/> ₄	A Good Deal <input type="checkbox"/> ₅	A Great Deal <input type="checkbox"/> ₆	A Very Great Deal <input type="checkbox"/> ₇

IN GENERAL, HOW MUCH OF THE TIME DURING THE LAST 2 WEEKS DID YOU:

		None of the Time	Hardly Any of the Time	A Little of the Time	Some of the Time	A Good Bit of the Time	Most of the Time	All of the Time
07	7. Feel CONCERNED ABOUT HAVING ASTHMA?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
08	8. Feel SHORT OF BREATH as a result of your asthma?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
09	9. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO CIGARETTE SMOKE?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
10	10. Experience a WHEEZE in your chest?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
11	11. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF CIGARETTE SMOKE?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

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		None	Very Little	Some	Moderate Amount	A Good Deal	A Great Deal	A Very Great Deal
12	12. How much discomfort or distress have you felt over the last 2 weeks as a result of COUGHING?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

IN GENERAL, HOW MUCH OF THE TIME DURING THE LAST 2 WEEKS DID YOU:

		None of the Time	Hardly Any of the Time	A Little of the Time	Some of the Time	A Good Bit of the Time	Most of the Time	All of the Time
13	13. Feel FRUSTRATED as a result of your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
14	14. Experience a feeling of CHEST HEAVINESS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
15	15. Feel CONCERNED ABOUT THE NEED TO USE MEDICATION for your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
16	16. Feel the need to CLEAR YOUR THROAT?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
17	17. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO DUST?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
18	18. Experience DIFFICULTY BREATHING OUT as a result of your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
19	19. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF DUST?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
20	20. WAKE UP IN THE MORNING WITH ASTHMA SYMPTOMS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
21	21. Feel AFRAID OF NOT HAVING YOUR ASTHMA MEDICATION AVAILABLE?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
22	22. Feel bothered by HEAVY BREATHING?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
23	23. Experience asthma symptoms as a RESULT OF THE WEATHER OR AIR POLLUTION?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
24	24. Were you WOKEN AT NIGHT by your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

