Asthma Clinical Research Setwork NIHNHLBI

QUALITY OF LIFE QUESTIONNAIRE

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

QOL

(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	Activity 1			\square_3	$\square_{_4}$	\square_{5}	\square_6	\square_7	
02	2	Activity 2			\square_3	\square_4	\square_{5}	\square_6	\square_7	
03	3	Activity 3			\square_3	\square_4	\square_{5}	\square_6	\square_7	
04	4	Activity 4			\square_3		\square_{5}		 7	
05	5	Activity 5			\square_3	\square_4		\square_6	\square_7	
06	6.	How much discomfort or distress have	None	Very Little	Some	Moderate Amount	A Good Deal		A Very reat Deal	
		you felt over the last 2 weeks as a result of CHEST TIGHTNESS?			\square_3	\square_4		\square_6	\square_7	
	IN GENERAL, <u>HOW MUCH OF THE TIME</u> DURING THE LAST 2 WEEKS DID Y0U:									
			None of	Hardly Any	A Little	Some of	A Good Bit	Most of	All of	
	_		the Time	of the Time	of the Time	the Time	of the Time	the Time	the Time	
07	7.	Feel CONCERNED ABOUT HAVING ASTHMA?			\square_3	4		4 6	4 7	
08	8.	Feel SHORT OF BREATH as a result of your asthma?			\square_3	 4	 5	 6	 7	
09	9.	Experience asthma symptoms as a RESULT OF BEING EXPOSED TO CIGARETTE SMOKE?	 1				□ ₅		7	
10	10.	Experience a WHEEZE in your chest?			\square_3				\square_7	
11	11.	Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF CIGARETTE SMOKE?			\square_3		□ ₅		 7	

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12	12.	How much discomfort or distress have you felt over the last 2 weeks as a	None	Very Little	Some	Moderate Amount	Deal	A Great Deal	A Very Great Deal
		result of COUGHING?	∟ 1	_ 2			□ ₅	4 6	4 7
	IN G	ENERAL, <u>HOW MUCH OF THE TIME</u> DU	RING TH	HE LAST 2	WEEKS D	ID YOU:			
			None of	Hardly Any	A Little	Some of	A Good Bit	Most of	All of
13	13.	Feel FRUSTRATED as a result of your asthma?	the Time	of the Time	of the Time	the Time	of the Time	the Time	the Time
14	14.	Experience a feeling of CHEST HEAVINESS?							\square_7
15	15.	Feel CONCERNED ABOUT THE NEED TO USE MEDICATION for your asthma?							 7
16	16.	Feel the need to CLEAR YOUR THROAT?					 5		 7
17	17.	Experience asthma symptoms as a RESULT OF BEING EXPOSED TO DUS	□ ₁				□ ₅		 7
18	18.	Experience DIFFICULTY BREATHING OUT as a result of your asthma?			\square_3				 7
19	19.	Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF DUS	□ ₁		\square_3				 7
20	20.	WAKE UP IN THE MORNING WITH ASTHMA SYMPTOMS?			\square_3		□ ₅		7
21	21.	Feel AFRAID OF NOT HAVING YOUR ASTHMA MEDICATION AVAILABLE?			\square_3				□ ₇
22	22.	Feel bothered by HEAVY BREATHING?			\square_3		□ ₅		
23	23.				\square_3			\square_6	 7
24	24.	Were you WOKEN AT NIGHT by your asthma?	_ 1						

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			None of	Hardly Any	A Little	Some of	A Good Bit	Most of	All of
			the Time	of the Time	of the Time	the Time	of the Time	the Time	the Time
25	25.	AVOID OR LIMIT GOING OUTSIDE BECAUSE OF THE WEATHER OR AIR POLLUTION?			\square_3				7
	IN G	SENERAL, <u>HOW MUCH OF THE TIME</u> DU	IRING TH	E LAST 2 \	WEEKS DII	D YOU:			
			None of	Hardly Any	A Little	Some of	A Good Bit	Most of	All of
			the Time	of the Time	of the Time	the Time	of the Time	the Time	the Time
26	26.	Experience asthma symptoms as a RESULT OF BEING EXPOSED TO STRONG SMELLS OR PERFUME?							□ ₇
27	27.	Feel AFRAID OF GETTING OUT OF BREATH?			\square_3				 7
28	28.	Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF STRONG SMELLS OR PERFUME?							 7
29	29.	Has your asthma INTERFERED WITH GETTING A GOOD NIGHT'S SLEEP?							7
30	30.	Have a feeling of FIGHTING FOR AIR?			\square_3				7
31	31.	Think of the OVERALL RANGE OF	No Limitation		Very Few Not Done		Several Not Done		Most Not Done
		ACTIVITIES that you would have liked to have done during the last 2 weeks. How much has your range of activities been limited by your asthma?			\square_3			\square_6	
	22	Overell among ALL THE ACTIVITIES	Not at all Limited	A Little Limitation	Some Limitation	Moderate Limitation	Very Limited	Extremely Limited	Totally Limited
32	32.	Overall, among ALL THE ACTIVITIES that you have done during the last 2 weeks, how limited have you been by your asthma?			\square_3				