

QUALITY OF LIFE QUESTIONNAIRE

Subject ID: 2
 Subject Initials: _____
 Visit Number: _____
 Visit Date: _____ / _____ / _____
 month day year
 Interviewer ID: _____

(Subject 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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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

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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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_12	12. How much discomfort or distress have you felt over the last 2 weeks as a result of COUGHING?	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

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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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_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
QOL_25	25. AVOID OR LIMIT GOING OUTSIDE BECAUSE 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

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		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
QOL_26	26. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO STRONG SMELLS OR PERFUME?	<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
QOL_27	27. Feel AFRAID OF GETTING OUT OF BREATH?	<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
QOL_28	28. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF STRONG SMELLS OR PERFUME?	<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
QOL_29	29. Has your asthma INTERFERED WITH GETTING A GOOD NIGHT'S SLEEP?	<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
QOL_30	30. Have a feeling of FIGHTING FOR AIR?	<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
		No Limitation		Very Few Not Done		Several Not Done		Most Not Done
QOL_31	31. Think of the OVERALL RANGE OF 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?	<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
		Not at all Limited	A Little Limitation	Some Limitation	Moderate Limitation	Very Limited	Extremely Limited	Totally Limited
QOL_32	32. Overall, among ALL THE ACTIVITIES that you have done during the last 2 weeks, how limited have you been 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