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2010 JACOBSEN DRIVE
NORMAL, IL 61761

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Name _____

Date _____

Asthma Quality of Life Questionnaire

Activities

We would like you to think of the ways in which asthma limits your life. We are particularly interested in activities that you still do, but are limited by your asthma. You may be limited because you do these activities less often, or not quite as well, or because they are less enjoyable. These should be activities that you do frequently and you feel are important in your day-to-day life. These should also be activities that you intend to do regularly throughout treatment.

Please think of all the activities that you have done during the last 2 weeks; activities that you feel were limited as a result of your asthma.

Here is a list of activities in which some people with asthma are limited. We hope this will help you to identify the 5 most important activities that have been limited by you asthma in the last 2 weeks.

- | | |
|-------------------------------------|-----------------------|
| 1. Mopping/scrubbing the floor | 15. Shoveling Snow |
| 2. Cleaning Snow off your car | 16. Singing |
| 3. Doing regular social activities | 17. Sleeping |
| 4. Doing home maintenance | 18. Dancing |
| 5. Having sexual intercourse | 19. Talking |
| 6. Doing housework | 20. Gardening |
| 7. Running upstairs or uphill | 21. Vacuuming |
| 8. Jogging, exercising, or running | 22. Hurrying |
| 9. Visiting with friends/relatives | 23. Laughing |
| 10. Going for a walk | 24. Bicycling |
| 11. Carrying out activities at work | 25. Mowing the lawn |
| 12. Walking upstairs or uphill | 26. Playing with pets |
| 13. Playing with children | 27. Playing sports |
| 14. Woodwork or carpentry | 28. Other _____ |

Please write your 5 most important activities on the lines below and then tell us how much you have been limited by your asthma in each activity during the past 2 weeks. Please list in order of importance. Circle the appropriate rating.

1-5. How much have you been limited in the last 2 weeks?

	Totally	Extremely	Very	Moderate	Some	A little	Not at all
1. _____	1	2	3	4	5	6	7
2. _____	1	2	3	4	5	6	7
3. _____	1	2	3	4	5	6	7
4. _____	1	2	3	4	5	6	7
5. _____	1	2	3	4	5	6	7

6. How much discomfort/distress have you felt over the last 2 weeks as a result of **chest tightness**?

A Very Great Deal	A Great Deal	A Good Deal	Moderate Amount	Some	Very Little	NONE
1	2	3	4	5	6	7

In general, how much of the time during the last 2 weeks did you:

	ALL	Most	A good bit	Some	A Little	Hardly Any	NONE
7. Feel concerned about having asthma ?	1	2	3	4	5	6	7
8. Feel short of breath as a result of your asthma?	1	2	3	4	5	6	7
9. Experience asthma symptoms as a result of regular daily physical activity ?	1	2	3	4	5	6	7
10. Experience a wheeze in your chest?	1	2	3	4	5	6	7

11. Feel you had to **avoid a situation or environment because of cigarette smoke?** 1 2 3 4 5 6 7

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

A Very Great Deal	A Great Deal	A Good Deal	Moderate Amount	Some	Very Little	NONE
1	2	3	4	5	6	7

In general, how much of the time during the last 2 weeks did you:

	ALL	Most	A good bit	Some	A Little	Hardly Any	NONE
13. Feel frustrated as a result of your asthma?	1	2	3	4	5	6	7
14. Experience a feeling of chest heaviness?	1	2	3	4	5	6	7
15. Feel concerned about the need to use medication for your asthma?	1	2	3	4	5	6	7
16. Feel the need to clear your throat?	1	2	3	4	5	6	7
17. Experience asthma symptoms as a result of being exposed to dust?	1	2	3	4	5	6	7
18. Experience difficulty breathing out as a result of your asthma?	1	2	3	4	5	6	7
19. Feel you had to avoid a situation/environment because of dust?	1	2	3	4	5	6	7
20. Wake up in the morning							

with asthma symptoms?	1	2	3	4	5	6	7
21. Feel afraid of not having your asthma medication available?	1	2	3	4	5	6	7
22. Feel bothered by heavy breathing?	1	2	3	4	5	6	7

In general, how much of the time during the last 2 weeks did you:

	ALL	Most	A good bit	Some	A Little	Hardly Any	NONE
23. Experience asthma symptoms as a result of the weather or air pollution outside?	1	2	3	4	5	6	7
24. Were woken at night by your asthma?	1	2	3	4	5	6	7
25. Avoid or limit going outside because of weather or air pollution?	1	2	3	4	5	6	7
26. Experience asthma symptoms as a result of being exposed to strong smells or perfumes?	1	2	3	4	5	6	7
27. Feel afraid of getting out of breath?	1	2	3	4	5	6	7 28.
Feel you had to avoid a situation because of strong smells or perfume?	1	2	3	4	5	6	7
29. Has your asthma interfered with getting a good night's sleep?	1	2	3	4	5	6	7
30. Have a feeling of fighting for air?	1	2	3	4	5	6	7
How much have you been limited in the last 2 weeks?							

Totally Extremely Very Moderate Some A little Not at all

31. In the overall range of activities you enjoy?	1	2	3	4	5	6	7
32. In the overall activities you did ?	1	2	3	4	5	6	7

Practical Problems

How troubled have you been by each of these problems during the last week as a result of your nose eye symptoms?

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
a. Inconvenience of having to carry tissues	0	1	2	3	4	5	6
b. Need to rub eyes or nose	0	1	2	3	4	5	6
c. Need to blow nose repeatedly	0	1	2	3	4	5	6

Nasal Symptoms

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
a. Stuffy/Blocked	0	1	2	3	4	5	6
b. Runny	0	1	2	3	4	5	6
c. Sneezing	0	1	2	3	4	5	6
d. Post Nasal Drip	0	1	2	3	4	5	6

Eye Symptoms

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
a. Itchy Eyes	0	1	2	3	4	5	6
b. Watery Eyes	0	1	2	3	4	5	6
c. Sore Eyes	0	1	2	3	4	5	6
d. Swollen Eyes	0	1	2	3	4	5	6

How troubled have you been with these sleep problems during the last week because of your nose/eye symptoms?

Sleep

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
a. Difficulty going to sleep	0	1	2	3	4	5	6
b. Wake up during the night	0	1	2	3	4	5	6
c. Lack of a good night's sleep	0	1	2	3	4	5	6

Non-Hayfever Symptoms

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
a. Fatigue	0	1	2	3	4	5	6
b. Thirst	0	1	2	3	4	5	6
c. Reduced Productivity	0	1	2	3	4	5	6
d. Tiredness	0	1	2	3	4	5	6
e. Poor Concentration	0	1	2	3	4	5	6
f. Headache	0	1	2	3	4	5	6
g. Worn out	0	1	2	3	4	5	6

Identify **3** activities that have been limited by nose/eye symptoms during the previous week and record them on the lines below. Please use the top 3 activities from page 2.

Activities

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
1. _____	0	1	2	3	4	5	6
2. _____	0	1	2	3	4	5	6
3. _____	0	1	2	3	4	5	6

Emotional

	None	Hardly at all	Somewhat	Moderately	Quite a bit	Very much	Extremely
a. Frustrated	0	1	2	3	4	5	6
b. Impatient or Restless	0	1	2	3	4	5	6
c. Irritable	0	1	2	3	4	5	6
d. Embarrassed by your symptoms	0	1	2	3	4	5	6

THE END!