

THE ST. GEORGE'S HOSPITAL RESPIRATORY QUESTIONNAIRE

This questionnaire is designed to help us learn much more about how your breathing is troubling you and how it affects your life. We are using it to find out which aspects of your illness cause you most problem, rather than what the doctors and nurses think your problems are.

Please read the instructions carefully and ask if you do not understand any thing. Do not spend too long deciding about your answers.

Name: _____ Date: _____

I.D. no. _____

Age: _____

Sex: Male/Female

PART 1

QUESTIONS ABOUT HOW MUCH CHEST TROUBLE YOU HAVE HAD OVER THE LAST YEAR. PLEASE TICK IN ONE BOX FOR EACH QUESTION.

	most days a week	several days a week	a few days a month	only with chest infections	not at all
1) Over the last year, I have coughed :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Over the last year, I have brought up phlegm (sputum) :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Over the last year, I have had shortness of breath :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Over the last year, I have had attacks of wheezing :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) During the last year, how many severe or very unpleasant attacks of chest trouble have you had :				more than 3 attacks.....	<input type="checkbox"/>
				3 attacks.....	<input type="checkbox"/>
				2 attacks.....	<input type="checkbox"/>
				1 attack.....	<input type="checkbox"/>
				no attacks.....	<input type="checkbox"/>
6) How long did the worst attack of chest trouble last: (Go to Question 7 if you had no severe attacks)				a week or more.....	<input type="checkbox"/>
				3 or more days.....	<input type="checkbox"/>
				1 or 2 days.....	<input type="checkbox"/>
				less than a day.....	<input type="checkbox"/>
7) Over the last year, in an average week, how many good days (with little chest trouble) have you had:				no good days	<input type="checkbox"/>
				1 or 2 good days	<input type="checkbox"/>
				3 or 4 good days	<input type="checkbox"/>
				nearly every day is good.....	<input type="checkbox"/>
				every day is good.....	<input type="checkbox"/>
8) If you have a wheeze, is it worse in the morning:				no.....	<input type="checkbox"/>
				yes.....	<input type="checkbox"/>

PART 2

SECTION 1

HOW WOULD YOU DESCRIBE YOUR CHEST CONDITION ? (PLEASE TICK IN ONE BOX ONLY)

- | | |
|--|--------------------------|
| the most important problem I have..... | <input type="checkbox"/> |
| causes me quite a lot a problems..... | <input type="checkbox"/> |
| causes me a few problems..... | <input type="checkbox"/> |
| causes no problem..... | <input type="checkbox"/> |

IF YOU HAVE EVER HAD PAID EMPLOYMENT, PLEASE TICK ONE OF THESE:

- | | |
|---|--------------------------|
| my chest trouble made me stop work altogether..... | <input type="checkbox"/> |
| my chest trouble interferes with my work or made me change my work..... | <input type="checkbox"/> |
| my chest trouble does not affect my work..... | <input type="checkbox"/> |

SECTION 2 : QUESTIONS ABOUT WHAT ACTIVITIES USUALLY MAKE YOU FEEL BREATHLESS THESE DAYS.

FOR EACH ITEM, PLEASE TICK IN THE BOX FOR EITHER TRUE OR FALSE AS IT APPLIES TO YOU

- | | | |
|------------------------------------|-------------------------------|--------------------------------|
| Sitting or lying still..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Getting washed or dressed..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Walking around the home..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Walking outside on the level..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Walking up a flight of stairs..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Walking up hills..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Playing sports or games..... | <input type="checkbox"/> True | <input type="checkbox"/> False |

SECTION 3 : SOME MORE QUESTIONS ABOUT YOUR COUGH AND BREATHLESSNESS THESE DAYS.

FOR EACH ITEM, PLEASE TICK IN THE BOX FOR EITHER TRUE OR FALSE AS IT APPLIES TO YOU

- | | | |
|--|-------------------------------|--------------------------------|
| My cough hurts..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| My cough makes me tired..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I am breathless when I talk..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I am breathless when I bend over..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| My cough or breathing disturbs my sleep..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I get exhausted easily..... | <input type="checkbox"/> True | <input type="checkbox"/> False |

SECTION 4 : QUESTIONS ABOUT OTHER EFFECTS THAT YOUR CHEST TROUBLE MAY HAVE ON YOU THESE DAY

FOR EACH ITEM, PLEASE TICK IN THE BOX FOR EITHER TRUE OR FALSE AS IT APPLIES TO YOU

- | | | |
|---|-------------------------------|--------------------------------|
| My cough or breathing is embarrassing in public..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| My chest trouble is a nuisance to my family, friends or neighbours..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I get afraid or panic when I cannot get my breath..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I feel that I am not in control of my chest problem..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I do not expect my chest to get any better..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I have become frail or an invalid because of my chest..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Exercise is not safe for me..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| Everything seems too much of an effort..... | <input type="checkbox"/> True | <input type="checkbox"/> False |

SECTION 5 : QUESTIONS ABOUT YOUR MEDICATION. IF YOU ARE RECEIVING NO

MEDICATION GO STRAIGHT TO SECTION 6.

TO COMPLETE THIS SECTION PLEASE TICK IN THE BOX FOR EITHER TRUE OR FALSE AS IT APPLIES TO YOU

- | | | |
|--|-------------------------------|--------------------------------|
| My medication does not help me very much..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I get embarrassed using my medication in public | <input type="checkbox"/> True | <input type="checkbox"/> False |
| I have unpleasant side effects from my medication..... | <input type="checkbox"/> True | <input type="checkbox"/> False |
| My medication interferes with my life a lot..... | <input type="checkbox"/> True | <input type="checkbox"/> False |

SECTION 6 : THESE ARE QUESTIONS ABOUT HOW YOUR ACTIVITIES MIGHT BE AFFECTED BY YOUR BREATHING.

FOR EACH QUESTION, PLEASE TICK **TRUE** IF ONE OR MORE OF THE PARTS OF THE QUESTION APPLIES TO YOU BECAUSE OF YOUR BREATHING. OTHERWISE TICK **FALSE**.

- I take a long time to get washed or dressed..... True False
- I cannot take a bath or shower, or I take a long time..... True False
- I walk slower than other people, or I stop for rests..... True False
- Jobs such as housework take a long time, or I have to stop for rests..... True False
- If I walk up one flight of stairs, I have to go slowly or stop..... True False
- If I hurry or walk fast, I have to stop or slow down..... True False

- My breathing makes it difficult to do things such as walk up hills, carrying things up stairs, light gardening such as weeding, dance, play bowls or play golf..... True False

- My breathing makes it difficult to do things such as carry heavy loads, dig the garden or shovel snow, jog or walk at 5 miles per hour, play tennis or swim..... True False

- My breathing makes it difficult to do things such as very heavy manual work, run, cycle, swim fast or play competitive sports..... True False

SECTION 7 : WE WOULD LIKE TO KNOW HOW YOUR CHEST TROUBLE USUALLY AFFECTS YOUR DAILY LIFE.

PLEASE TICK EITHER **TRUE** OR **FALSE**
(REMEMBER THAT **TRUE** ONLY APPLIES TO YOU IF YOU CANNOT DO SOMETHING BECAUSE OF YOUR BREATHING)

- I cannot play sports or games..... True False
- I cannot go out for entertainment or recreation..... True False
- I cannot go out of the house to do the shopping..... True False
- I cannot do housework..... True False
- I cannot move far from my bed or chair..... True False

HERE IS A LIST OF OTHER ACTIVITIES THAT YOUR CHEST TROUBLE MAY PREVENT YOU DOING. (YOU DO NOT HAVE TO TICK THESE, THEY ARE JUST TO REMIND YOU OF WAYS IN WHICH YOUR BREATHLESSNESS MAY AFFECT YOU) :

- GOING FOR WALKS OR WALKING THE DOG
- DOING THINGS AT HOME OR IN THE GARDEN
- SEXUAL INTERCOURSE
- GOING OUT TO CHURCH, OR PLACE OF ENTERTAINMENT
- GOING OUT IN BAD WEATHER OR INTO SMOKY ROOMS
- VISITING FAMILY OR FRIENDS OR PLAYING WITH CHILDREN

PLEASE WRITE IN ANY OTHER IMPORTANT ACTIVITIES THAT YOUR CHEST TROUBLE MAY STOP YOU DOING:

NOW, WOULD YOU TICK IN THE BOX (ONE ONLY) WHICH YOU THINK BEST DESCRIBES HOW YOUR CHEST AFFECTS YOU:

- It does not stop me doing anything I would like to do.....
- It stops me doing one or two things I would like to do.....
- It stops me doing most of the things I would like to do.....
- It stops me doing everything I would like to do.....