Asthma Clinical Research Network BAGS
NIH/NHLBI

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. Activity 1	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
02	2. Activity 2	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
03	3. Activity 3	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
04	4. Activity 4	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
05	5. Activity 5	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

		None	Very Little	Some	Moderate Amount	A Good Deal	A Great Deal	A Very Great Deal
06	6. How much discomfort or distress have you felt over the last 2 weeks as a result of CHEST TIGHTNESS?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

IN GENERAL, HOW MUCH OF THE TIME DURING THE LAST 2 WEEKS DID Y0U:

		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?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
08	8. Feel SHORT OF BREATH as a result of your asthma?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
09	9. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO CIGARETTE SMOKE?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
10	10. Experience a WHEEZE in your chest?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
11	11. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF CIGARETTE SMOKE?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

		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?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 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?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
14	14. Experience a feeling of CHEST HEAVINESS?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
15	15. Feel CONCERNED ABOUT THE NEED TO USE MEDICATION for your asthma?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
16	16. Feel the need to CLEAR YOUR THROAT?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
17	17. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO DUST?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
18	18. Experience DIFFICULTY BREATHING OUT as a result of your asthma?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
19	19. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF DUST?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
20	20. WAKE UP IN THE MORNING WITH ASTHMA SYMPTOMS?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
21	21. Feel AFRAID OF NOT HAVING YOUR ASTHMA MEDICATION AVAILABLE?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
22	22. Feel bothered by HEAVY BREATHING?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
23	23. Experience asthma symptoms as a RESULT OF THE WEATHER OR AIR POLLUTION?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
24	24. Were you WOKEN AT NIGHT by your asthma?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

		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
25	25. AVOID OR LIMIT GOING OUTSIDE BECAUSE OF THE WEATHER OR AIR POLLUTION?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 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
26	26. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO STRONG SMELLS OR PERFUME?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
27	27. Feel AFRAID OF GETTING OUT OF BREATH?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
28	28. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF STRONG SMELLS OR PERFUME?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
29	29. Has your asthma INTERFERED WITH GETTING A GOOD NIGHT'S SLEEP?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
30	30. Have a feeling of FIGHTING FOR AIR?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

		No Limitation		Very Few Not Done		Several Not Done		Most Not Done
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?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

		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?	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7