

Participant ID			

Date							
D	D	M	M	Y	Y	Y	Y

Visit number



QOL-B

QUALITY OF LIFE QUESTIONNAIRE – BRONCHIECTASIS

Understanding the impact of your illness and treatments on your everyday life can help your doctor monitor your health and adjust your treatments. For this reason, we have developed a quality of life questionnaire specifically for people who have bronchiectasis. Thank you for your willingness to fill in this questionnaire.

Instructions: The following questions are about the current state of your health, as you perceive it. This information will allow us to better understand how you feel in your everyday life.

Please answer all the questions. There are **no** right or wrong answers! If you are not sure how to answer, choose the response that seems closest to your situation.

Continue to Next Page

Participant ID			

Date							
D	D	M	M	Y	Y	Y	Y



QUALITY OF LIFE QUESTIONNAIRE – BRONCHIECTASIS

Section I. Quality of Life

Please tick a box to indicate your answer.

During the past week, to what extent have you had difficulty:

	A lot of difficulty	Moderate difficulty	A little difficulty	No difficulty
1. Performing vigorous activities, such as gardening or exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Walking as fast as other people (family, friends, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Carrying heavy things, such as books or shopping bags	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Climbing one flight of stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past week, indicate how often:

	Always	Often	Sometimes	Never
5. You felt well.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. You felt tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. You felt anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. You felt energetic.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. You felt exhausted.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. You felt sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. You felt depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently on any treatments (such as: oral or inhaled medications; a PEP, Acapella® or Flutter® device; chest physiotherapy; or Vest) for bronchiectasis?

- Yes No (Go to Question 15 on the next page)

Please circle a number to indicate your answer. Please choose only one answer for each question.

12. To what extent do your treatments for bronchiectasis make your daily life more difficult?

1. Not at all
2. A little
3. Moderately
4. A lot

13. How much time do you currently spend each day on your treatments for bronchiectasis?

1. A lot
2. A moderate amount
3. A little
4. Almost none

14. How difficult is it for you to fit in your treatments for bronchiectasis each day?

1. Not at all
2. A little
3. Moderately
4. Very

Continue to Next Page

Participant ID			

Date							
D	D	M	M	Y	Y	Y	Y



QUALITY OF LIFE QUESTIONNAIRE – BRONCHIECTASIS

Please circle a number to indicate your answer. Please choose only one answer for each question.

15. How do you think your health is now?
1. Excellent
 2. Good
 3. Fair
 4. Poor

Please tick a box to indicate your answer.

Thinking about your health during the past week, indicate the extent to which each sentence is true for you.

	Completely true	Mostly true	A little true	Not at all true	
16. I have to limit vigorous activities, such as walking or exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. I have to stay at home more than I want to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. I am worried about being exposed to other people who are ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doesn't apply
19. It is difficult to be intimate with a partner (kissing, hugging, sexual activity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. I lead a normal life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. I am concerned that my health will get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. I think my coughing bothers other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. I often feel lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. I feel healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. It is difficult to make plans for the future (holidays, attending family events, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. I feel embarrassed when I am coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please circle a number or tick a box to indicate your answer.

During the past week:

27. To what extent did you have trouble keeping up with your job, housework, or other daily activities?
1. You have had no trouble keeping up
 2. You have managed to keep up but it has been difficult
 3. You have been behind
 4. You have not been able to do these activities at all

	Always	Often	Sometimes	Never
28. How often does having bronchiectasis get in the way of meeting your work, household, family, or personal goals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue to Next Page

Participant ID			

Date							
D	D	M	M	Y	Y	Y	Y



QUALITY OF LIFE QUESTIONNAIRE – BRONCHIECTASIS

Section II. Respiratory Symptoms

Please tick a box to indicate your answer.

Indicate how you have been feeling during the past week:

	A lot	A moderate amount	A little	Not at all
29. Have you felt congestion (fullness) in your chest?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you been coughing during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you had to cough up sputum?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Has your sputum been mostly:				
	<input type="checkbox"/> Clear	<input type="checkbox"/> Clear to yellow	<input type="checkbox"/> Yellowish-green	
	<input type="checkbox"/> Brownish-dark	<input type="checkbox"/> Green with traces of blood	<input type="checkbox"/> Don't know	

How often during the past week:

	Always	Often	Sometimes	Never
33. Have you had shortness of breath when being more active, such as when doing housework or gardening?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you had wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you had chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you had shortness of breath when talking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Have you woken up during the night because you were coughing?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make sure you have answered all the questions.

THANK YOU FOR YOUR COOPERATION!