Participant ID			

Date							
D	D	M	M	Y	Y	Y	Y

Visit number

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.

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Participant ID			

Date							
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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	☐	☐	☐	☐
2. Walking as fast as other people (family, friends, etc.)	☐	☐	☐	☐
3. Carrying heavy things, such as books or shopping bags	☐	☐	☐	☐
4. Climbing one flight of stairs	☐	☐	☐	☐

*During the past **week**, indicate how often:*	Always	Often	Sometimes	Never
5. You felt well	☐	☐	☐	☐
6. You felt tired	☐	☐	☐	☐
7. You felt anxious	☐	☐	☐	☐
8. You felt energetic	☐	☐	☐	☐
9. You felt exhausted	☐	☐	☐	☐
10. You felt sad	☐	☐	☐	☐
11. You felt depressed	☐	☐	☐	☐

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

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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	☐	☐	☐	☐	
17. I have to stay at home more than I want to	☐	☐	☐	☐	
18. I am worried about being exposed to other people who are ill	☐	☐	☐	☐	**Doesn't apply**
19. It is difficult to be intimate with a partner (kissing, hugging, sexual activity)	☐	☐	☐	☐	
20. I lead a normal life	☐	☐	☐	☐	
21. I am concerned that my health will get worse	☐	☐	☐	☐	
22. I think my coughing bothers other people	☐	☐	☐	☐	
23. I often feel lonely...	☐	☐	☐	☐	
24. I feel healthy	☐	☐	☐	☐	
25. It is difficult to make plans for the future (holidays, attending family events, etc.)	☐	☐	☐		
26. I feel embarrassed when I am coughing	☐	☐	☐	☐	

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?	☐	☐	☐	☐

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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?....................................	☐	☐	☐	☐
30. Have you been coughing during the day?	☐	☐	☐	☐
31. Have you had to cough up sputum?...	☐	☐	☐	☐

32. Has your sputum been mostly:

☐ Clear ☐ Clear to yellow ☐ Yellowish-green

☐ Brownish-dark ☐ Green with traces of blood ☐ 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?...	☐	☐	☐	☐
34. Have you had wheezing?	☐	☐	☐	☐
35. Have you had chest pain?	☐	☐	☐	☐
36. Have you had shortness of breath when talking?	☐	☐	☐	☐
37. Have you woken up during the night because you were coughing?..........	☐	☐	☐	☐

Please make sure you have answered all the questions.

THANK YOU FOR YOUR COOPERATION!

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