

ST. GEORGE'S RESPIRATORY QUESTIONNAIRE ORIGINAL ENGLISH VERSION

ST. GEORGE'S RESPIRATORY QUESTIONNAIRE (SGRQ)

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 problems, rather than what the doctors and nurses think your problems are.

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

Participant ID				

Date							
D	D	M	M	Y	Y	Y	Y

Visit Number

Before completing the rest of the questionnaire:

Please tick in one box to show how you describe your current health:

Very good Good Fair Poor Very poor

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UK/ English (original) version

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St. George's Respiratory Questionnaire

Participant ID				

PART 1

Questions about how much chest trouble you have had over the past 3 months.

Please tick () 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 past 3 months, I have coughed: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Over the past 3 months, I have brought up phlegm (sputum): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Over the past 3 months, I have had shortness of breath: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Over the past 3 months, I have had attacks of wheezing: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 3 months how many severe or very unpleasant attacks of chest trouble have you had? | | | | | |

Please tick () one:

- more than 3 attacks
- 3 attacks
- 2 attacks
- 1 attack
- no attacks

6. How long did the worst attack of chest trouble last?
(Go to question 7 if you had no severe attacks)

Please tick () one:

- a week or more
- 3 or more days
- 1 or 2 days
- less than a day

7. Over the past 3 months, in an average week, how many good days (with little chest trouble) have you had?

Please tick () one:

- No good days
- 1 or 2 good days
- 3 or 4 good days
- nearly every day is good
- every day is good

8. If you have a wheeze, is it worse in the morning?

Please tick () one:

- No
- Yes

Participant ID				

St. George's Respiratory Questionnaire PART 2

Section 1

How would you describe your chest condition?

Please tick (one):

- The most important problem I have
- Causes me quite a lot of problems
- Causes me a few problems
- Causes no problem

If you have ever had paid employment.

Please tick (one):

- My chest trouble made me stop work altogether
- My chest trouble interferes with my work or made me change my work
- My chest trouble does not affect my work

Section 2

Questions about what activities usually make you feel breathless these days.

Please tick (in **each box** that applies to you **these days**:

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

Participant ID				

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St. George's Respiratory Questionnaire PART 2

Participant ID				

St. George's Respiratory Questionnaire PART 2

Section 3

Some more questions about your cough and breathlessness these days.

Please tick () in **each box** that applies to you **these days**:

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

Section 4

Questions about other effects that your chest trouble may have on you these days.

Please tick () in **each box** that applies to you **these days**:

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

Section 5

Questions about your medication, if you are receiving no medication go straight to section 6.

Please tick () in **each box** that applies to you **these days**:

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

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St. George's Respiratory Questionnaire PART 2

Section 6

These are questions about how your activities might be affected by your breathing.

Please tick () in **each box** that applies to you **because of your breathing**:

	True	False
I take a long time to get washed or dressed	<input type="checkbox"/>	<input type="checkbox"/>
I cannot take a bath or shower, or I take a long time	<input type="checkbox"/>	<input type="checkbox"/>
I walk slower than other people, or I stop for rests	<input type="checkbox"/>	<input type="checkbox"/>
Jobs such as housework take a long time, or I have to stop for rests	<input type="checkbox"/>	<input type="checkbox"/>
If I walk up one flight of stairs, I have to go slowly or stop	<input type="checkbox"/>	<input type="checkbox"/>
If I hurry or walk fast, I have to stop or slow down	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
My breathing makes it difficult to do things such as very heavy manual work, run, cycle, swim fast or play competitive sports	<input type="checkbox"/>	<input type="checkbox"/>

Section 7

We would like to know how your chest usually affects your daily life.

Please tick () in **each box** that applies to you **because of your chest trouble**:

	True	False
I cannot play sports or games	<input type="checkbox"/>	<input type="checkbox"/>
I cannot go out for entertainment or recreation	<input type="checkbox"/>	<input type="checkbox"/>
I cannot go out of the house to do the shopping	<input type="checkbox"/>	<input type="checkbox"/>
I cannot do housework	<input type="checkbox"/>	<input type="checkbox"/>
I cannot move far from my bed or chair	<input type="checkbox"/>	<input type="checkbox"/>

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St. George's Respiratory Questionnaire

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, pub, club 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:

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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

Thank you for filling in this questionnaire. Before you finish would you please check to see that you have answered all the questions.