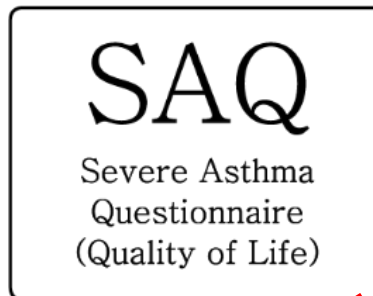


Date:

Name:

## Severe Asthma Questionnaire (SAQ)



This questionnaire measures the quality of life of people who have severe asthma.

Please show how difficult asthma makes your life using the scale:

1 = very, very difficult (worst possible)

2 = very difficult

3 = difficult

4 = moderately difficult

5 = slightly difficult

6 = very slightly difficult (just noticeable)

7 = no problem

Please take into account your **symptoms** of asthma, and **any side effects** from any of the medicines you take because you have severe asthma.

Circle the number that applies to you:

How difficult is this part of your life during the **last two weeks** because of your asthma symptoms and the side effects of your medicines?

	<i>Very, very difficult</i>				<i>No problem</i>		
1. My social life. For example: visiting friends, walking with friends, talking with friends, going to bars/restaurants, and parties.	1	2	3	4	5	6	7
2. My personal life. For example: washing, dressing, looking after myself, love life.	1	2	3	4	5	6	7
3. My leisure activities. For example: walking for pleasure, sports, exercise, travelling, taking vacations.	1	2	3	4	5	6	7
4. My jobs around the house. For example: housework, shopping, home maintenance, gardening.	1	2	3	4	5	6	7
5. My work or education. For example, missing days, can't do all I want to do.	1	2	3	4	5	6	7
					Leave blank if not in work or education		
6. My family life – how it affects <b>me</b> . For example: caring for children, family responsibilities.	1	2	3	4	5	6	7
7. My family life – how it affects <b>others</b> . For example: others taking time off work, problems with childcare, family members becoming upset.	1	2	3	4	5	6	7

	<i>Very, very difficult</i>				<i>No problem</i>		
8. Depression. For example, feeling sad, fed up, blue.	1	2	3	4	5	6	7
9. Irritable. For example, snap at people, get angrier than I should.	1	2	3	4	5	6	7
10. Anxiety in general. For example, worry about things, always on edge.	1	2	3	4	5	6	7
11. Worry that asthma may get worse. For example, medicines no longer help, more frequent attacks.	1	2	3	4	5	6	7
12. Worry about long term side effects of medicines. For example, worry about cataracts, diabetes, bone fracture.	1	2	3	4	5	6	7
13. Getting tired. For example, feeling tired for no reason, waking in the morning feeling tired.	1	2	3	4	5	6	7
14. Problems at night. For example, difficulty going to sleep, being woken very easily, waking often at night.	1	2	3	4	5	6	7
15. The way I look. For example, my weight, my skin bruises easily, using medicines in public, other people judging me.	1	2	3	4	5	6	7
16. Problems with food. For example, I find I get very hungry, I just can't stop eating, stomach problems (e.g., pain, bloating, etc.)	1	2	3	4	5	6	7

Use the scale on the left of this page to rate your **OVERALL** quality of life due to your **ASTHMA SYMPTOMS** and the **SIDE EFFECTS** of your medicines.

100 Perfect quality of life

95 Nearly perfect quality of life

90

85 Very good quality of life

80

75

70 Good quality of life

65

60 Moderately good quality of life

55

50

45

40 Somewhat bad quality of life

35

30

Bad quality of life

25

20

15 Very bad quality of life

10

5 Extremely bad quality of life

0 No quality of life

1. During the last **TWO WEEKS**,  
my quality of life has been

\_\_\_\_\_ write a number

2. During the month of the year when my  
asthma is at its **BEST**,  
my quality of life has been

\_\_\_\_\_ write a number

3. During the month of the year when my  
asthma is at its **WORST**,  
my quality of life has been

\_\_\_\_\_ write a number

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