Calgary Sleep Apnea Quality of Life Index (Interviewer)

This questionnaire has been designed to find out how you have been doing and feeling over the last 4 weeks. You will be questioned about the impact that sleep apnea and/or snoring may have had on your daily activities, your emotional functioning, and your social interactions, and about any symptoms they might have caused.

A. Daily Functioning

I. *Most important daily activity*. With regard to performing your most important, usual daily activity (e.g., work, school, child care, house- work, etc.) during the previous 4 weeks:

1. How much have you had to force yourself to do this activity? *[yellow card]*

2. How much of the time have you had to push yourself to remain alert while performing this activity? *[yellow card]*

3. How often have you adjusted your schedule to avoid this activity because you felt that you would be unable to remain alert while doing it? *[yellow card]*

4. How often do you use all of your energy to accomplish only this activity? *[yellow card]*

II. *Secondary activities*. With regard to activities other than your most important daily activity during the previous 4 weeks:

5. How much difficulty have you had finding the energy to exercise and/or do activities that you find relaxing (leisure activities)? *[green card]*

6. How much difficulty have you had finding the time for activities that you find relaxing? *[green card]*

7. How much difficulty have you had with your ability to do exercise and/or activities that you find relaxing? *[green card]*

8. How much difficulty have you had getting chores done around the place where you live? [green card]

III. *General functioning*. During the previous 4 weeks:

9. How much difficulty have you had with trying to remember things? *[green card]*

10. How much difficulty have you had with trying to concentrate? *[green card]*

11. How much of a problem have you had with having to fight to stay awake? *[red card]*

B. Social Interactions

The following questions pertain to how your relationship with your partner, other household members, relatives, and/or close friends have been during the previous 4 weeks. If you have not interacted with a partner, etc. in the previous 4 weeks, please try to work out how your relationship might have been with these people.

1. How upset have you been about being told that your snoring was bothersome or irritating? *[green*

card]

2. How upset have you been about having to (or possibly having to) sleep in separate bedrooms from your partner? *[green card]*

3. How upset have you been as a result of frequent conflicts or arguments? *[green card]*

4. How aware have you been of not wanting to talk to other people? *[green card]*

5. How much concern have you had about the need to make special sleeping arrangements if you were traveling and/or staying with someone? *[green card]*

6. How guilty have you felt about your relationship with family members or close personal friends? *[green card]*

7. How often have you looked for excuses for being tired? *[yellow card]*

8. How often have you experienced wanting to be left alone? *[yellow card]*

9. How often have you felt like not wanting to do things together with your partner, children, and/or friends? *[yellow card]*

10. How much of a problem have you felt there is with your relationship to the person who is closest to you? *[red card]*

11. How much of a problem have you had from not being involved in family activities? *[red card]*

12. How much of a problem have you had with inadequate and/or infrequent sexual intimacy? *[red card]*

13. How much of a problem have you had with a lack of interest in being around other people? *[red card]*

C. Emotional Functioning

With respect to how you have been feeling inside during the previous 4 weeks:

1. How often have you been feeling depressed, down, and/or hopeless? [yellow card]

2. How often have you been feeling anxious or fearful about what was wrong? [yellow card]

3. How often have you been feeling frustrated? [yellow card]

4. How often have you been feeling irritable and/or moody? [yellow card]

5. How often have you been feeling impatient? [yellow card]

6. How often have you been feeling that you are being unreasonable? [yellow card]

7. How often have you been getting easily upset? [yellow card]

8. How often have you experienced a tendency to become angry? [yellow card]

9. How often have you been feeling like you were unable to cope with everyday issues? [yellow card]

10. How concerned have you been about your weight? *[green card]*

11. How concerned have you been about heart problems (heart attacks or heart failure) and/or premature death? *[green card]*

D. Symptoms

Below is a list of symptoms that some people with sleep apnea and/or who snore may experience. As each symptom is read please indicate whether it has been a problem or not (answer yes or no). Circle those symptoms that you have experienced during the previous 4 wk. Once the list is finished please write down additional symptoms in the blank spaces you may have had that are not included in the list below. Next select the five most important symptoms you have experienced. For each of the five symptoms please identify how much of a problem it has been.

1. Decreased energy *[red card]*

2. Excessive fatigue *[red card]*

3. Feeling that ordinary activities require an extra effort to perform or complete *[red card]*

4. Falling asleep at inappropriate times or places *[red card]*

5. Falling asleep if not stimulated or active *[red card]*

6. Difficulty with a dry or sore mouth/throat upon awakening *[red card]*

7. Waking up often (more than twice) during the night *[red card]*

8. Difficulty returning to sleep if you wake up in the night *[red card]*

9. Concern about the times you stop breathing at night *[red card]*

10. Waking up at night feeling like you were choking *[red card]*

11. Waking up in the morning with a headache *[red card]*

12. Waking up in the morning feeling unrefreshed and/or tired *[red card]*

13. Waking up more than once per night to urinate *[red card]*

14. A feeling that your sleep is restless *[red card]*

15. Difficulty staying awake while reading *[red card]*

16. Difficulty staying awake while trying to carry on a conversation *[red card]*

17. Difficulty staying awake while trying to watch something (concert, movie, TV) *[red card]*

18. Fighting the urge to fall asleep while driving *[red card]*

19. A reluctance or inability to drive for 1 h 20. Concern regarding close calls while driving due to your inability to remain alert *[red card]*

21. Concern regarding your or other's safety when you're operating a motor vehicle or machinery *[red card]*

22. _____ *[red card]*

23. _____ *[red card]*

E. Treatment-related Symptoms

If you haven't had some type of therapy for sleep apnea and/or snoring leave this section blank. Below is a list of symptoms that some people who have been treated for sleep apnea and/or snoring may experience. As each symptom is read please indicate whether it has been a problem or not (answer yes or no). Circle those symptoms that you have experienced during the previous 4 weeks. Once the list is finished please write down any symptoms in the blank spaces you may have had that are not included in the list below. Next select the five most important symptoms you have experienced. For each of the five symptoms please identify how much of a problem it has been.

1. Runny nose *[red card]*

2. Stuffed or congested or blocked nose *[red card]*

3. Excessive dryness of the nose or throat passages, especially upon awakening *[red card]*

4. Soreness in the nose or throat passages *[red card]*

5. Headaches *[red card]*

6. Eye irritation *[red card]*

7. Ear pain *[red card]*

8. Waking up frequently during the night *[red card]*

9. Difficulty returning to sleep if you awaken *[red card]*

10. Air leakage from the nasal mask *[red card]*

11. Discomfort from the nasal mask *[red card]*

12. Marks or rash on your face *[red card]*

13. Complaints from your partner about the noise of the CPAP machine *[red card]*

14. Having fluid/food pass into your nose when you swallow *[red card]*

15. A change in how your voice sounds *[red card]*

16. Pain in the throat when swallowing *[red card]*

17. Pain or aching in your jaw joint or jaw muscles *[red card]*

18. Feeling self-conscious *[red card]*

19. Aching in your teeth that lasts at least an hour *[red card]*

20. Discomfort, aching, or tenderness of your gums *[red card]*

21. Hardship in being able to pay for the treatment *[red card]*

22. A sense of suffocation *[red card]*

23. Excessive salivation *[red card]*

24. Difficulty chewing in the morning *[red card]*

25. Difficulty chewing with your back teeth that persists most of the day *[red card]*

26. Movement of the teeth so that the upper and lower teeth no longer meet properly *[red card]*

27. _____ *[red card]*

28. _____ *[red card]*

F. Impact

Complete this section only if you have completed section E above.

I. Please think of the questions in Sections A, B, C, and D. Having been treated for your sleep apnea and/or snoring do you believe that overall there has been an improvement in your quality of life since you started treatment? If yes, how much of an impact on your quality of life has there been as reflected by the questions asked in Sections A, B, C, and D. Place a mark on the line.

Scale:

0———————————————————————————10

(no impact) (extremely large impact)

II. Please think of the symptoms that developed as a result of being treated for sleep apnea and/or snoring that you highlighted in Section E. How much of an impact on your quality of life have these symptoms had?

Scale:

0———————————————————————————10

(no impact) (extremely large impact)

Response Options

Yellow card
1. All the time
2. A large amount of the time
3. A moderate to large amount of the time
4. A moderate amount of the time
5. A small to moderate amount of the time
6. A small amount of the time
7. Not at all

Green card
1. A very large amount
2. A large amount
3. A moderate to large amount
4. A moderate amount
5. A small to moderate amount
6. A small amount
7. None

Red card
1. A very large problem
2. A large problem
3. A moderate to large problem
4. A moderate problem
5. A small to moderate problem
6. A small problem
7. No problem

***A note about scoring*.** To obtain mean scores for Domains A through D the total score of each domain should be divided by the total number of questions answered. When the SAQLI is administered after a therapeutic intervention, allowance has been made for the possibility that the treatment, even if it is "successful" may have some independent negative consequences on a patient's quality of life. The scores from Domain E (Treatment-related Symptoms), are dealt with in a manner different from that of the other four domains. First the scores require recoding (7 to 0, 6 to 1, 5 to 2, 4 to 3, 3 to 4, 2 to 5, and 1 to 6). For Domain E the mean recoded score is obtained by dividing the total score by 5 (regardless of how many symptoms were identified). Next, the mean value of the recoded scores needs to be weighted according to the impact of the treatment-related symptoms on quality of life in comparison with the impact of the improvement of Domains A through D. Weighting is accomplished by dividing the impact score for Domain E (a number from 0 to 10) by the impact score for Domains A through D (Section F of the SAQLI). If this quotient exceeds 1, the result should be reduced so that the weighting factor never exceeds 1. The mean recoded score from Domain E is multiplied by the weighting factor, and it is this product that should be subtracted from the sum of the mean scores from Domains A, B, C, and D.

To obtain the final SAQLI score the sum of the mean domain scores A, B, C, and D is divided by 4. If Domain E has been used after a therapeutic intervention, the SAQLI score is obtained by summing the mean domain scores A, B, C, and D, subtracting the mean re- coded Domain E score (that has been adjusted by the weighting factor described above) and dividing by 4.