

## Appendix 1

### ST. GEORGE'S RESPIRATORY QUESTIONNAIRE for COPD patients

(SGRQ-C)

*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.*

ID: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mm/yy)

*Before completing the rest of the questionnaire:*

*Please select one box to show how you describe your current health:*

Very good

☐

Good

☐

Fair

☐

Poor

☐

Very poor

☐

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UK/ English version COPD

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SGRQ-C - United Kingdom/English  
SGRQ-C\_AU1.0\_eng-GBori.doc

## St. George's Respiratory Questionnaire PART 1

Questions about how much chest trouble you have.

Please select **ONE** box for each question:

**Question 1.** I cough:

- most days a week..... ☐ a
- several days a week ..... ☐ b
- only with chest infections ..... ☐ c
- not at all..... ☐ d

**Question 2.** I bring up phlegm (sputum):

- most days a week..... ☐ a
- several days a week ..... ☐ b
- only with chest infections ..... ☐ c
- not at all..... ☐ d

**Question 3.** I have shortness of breath:

- most days a week..... ☐ a
- several days a week ..... ☐ b
- not at all..... ☐ c

**Question 4.** I have attacks of wheezing:

- most days a week..... ☐ a
- several days a week ..... ☐ b
- a few days a month ..... ☐ c
- only with chest infections ..... ☐ d
- not at all..... ☐ e

**Question 5.** How many attacks of chest trouble did you have during the last year?

3 or more attacks ..... ☐ a

1 or 2 attacks..... ☐ b

none ..... ☐ c

**Question 6.** How often do you have good days (with little chest trouble)?

no good days..... ☐ a

a few good days ..... ☐ b

most days are good ..... ☐ c

every day is good..... ☐ d

**Question 7.** If you have a wheeze, is it worse in the morning?

no ..... ☐

yes..... ☐

## St. George's Respiratory Questionnaire PART 2

### 8. *How would you describe your chest condition?*

Please select **ONE**:

- Causes me a lot of problems or is the most important problem I have ..... ☐ a
- Causes me a few problems ..... ☐ b
- Causes no problem ..... ☐ c

### 9. *Questions about what activities usually make you feel breathless.*

For each statement please select **the box** that applies to you **these days**:

	True	False	
Getting washed or dressed.....	<input type="checkbox"/>	<input type="checkbox"/>	a
Walking around the home.....	<input type="checkbox"/>	<input type="checkbox"/>	b
Walking outside on the level.....	<input type="checkbox"/>	<input type="checkbox"/>	c
Walking up a flight of stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	d
Walking up hills.....	<input type="checkbox"/>	<input type="checkbox"/>	e

## St. George's Respiratory Questionnaire PART 2

### 10. Some more questions about your cough and breathlessness.

For each statement please select *the box* that applies to you **these days**:

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

### 11. Questions about other effects that your chest trouble may have on you.

For each statement please select *the box* that applies to you **these days**:

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

## St. George's Respiratory Questionnaire PART 2

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

For each statement please select *the 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"/>	a
I cannot take a bath or shower, or I take a long time .....	<input type="checkbox"/>	<input type="checkbox"/>	b
I walk slower than other people, or I stop for rests .....	<input type="checkbox"/>	<input type="checkbox"/>	c
Jobs such as housework take a long time, or I have to stop for rests....	<input type="checkbox"/>	<input type="checkbox"/>	d
If I walk up one flight of stairs, I have to go slowly or stop .....	<input type="checkbox"/>	<input type="checkbox"/>	e
If I hurry or walk fast, I have to stop or slow down .....	<input type="checkbox"/>	<input type="checkbox"/>	f
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"/>	g
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"/>	h

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

For each statement please select *the box* that applies to you **because of your breathing**:

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

## St. George's Respiratory Questionnaire

14. *How does your chest trouble affect you?*

Please select *ONE*:

It does not stop me doing anything I would like to do ..... ☐ a

It stops me doing one or two things I would like to do..... ☐ b

It stops me doing most of the things I would like to do..... ☐ c

It stops me doing everything I would like to do..... ☐ d

*Thank you for filling in this questionnaire.*

*Before you finish, would you please check to see that you have answered all the questions.*

## Appendix 2: interview questions

- I.
  1. Age
  2. Gender
  3. Date of diagnosis of COPD: How long have you had this lung disease?
  4. Stage. Do you know how advanced your disease is?
  5. Current treatment: Could you tell me what treatment are you taking? What inhaler do you use?
  
- II.
  1. Are you a smoker? (definition of smoker refers to cigarette smoking)
  2. If yes, how many cigarettes do you smoke per day? How many years have you been an active smoker?
  3. What is your reason for smoking? Do you think it's not worth quitting now that it's too late?
  4. Have you ever tried to quit smoking? Do you tend to blame yourself for smoking/smoking for respiratory health problems?
  5. Do you often feel sad, hopeless or discouraged? How have you felt in the last few weeks?
  6. Do you ever feel that you have let someone down by the illness you have?
  7. What still brings you joy now?
  8. How do you sleep at night?
  9. Do you have difficulty falling asleep or wake up frequently during the night?
  10. Do you have the patience to read a newspaper or watch a movie on TV?
  11. Do you feel tired frequently, even after rest?
  12. Do you find it more difficult to concentrate on daily activities?
  13. Do you sometimes think you no longer have a purpose in life?
  14. What activities have you had to reduce or stop because of shortness of breath?
  15. Do you need help with daily activities (e.g. dressing, cooking, cleaning)?
  16. Do you have someone to talk to about how you are feeling? Do you feel the illness has affected your relationships with friends or your wife/husband?
  17. How would you rate your current life satisfaction on a scale of 1 to 10?
  18. What changes do you think would improve your quality of life?
  19. On a scale of 1-10, where would you rank your quality of life?
  20. What is it that most affects you that you can no longer do?

## Appendix 3: PHQ-9 questionnaire

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been  
bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  + 

(Healthcare professional: For interpretation of TOTAL, TOTAL:   
please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	<input type="text"/>
	Somewhat difficult	<input type="text"/>
	Very difficult	<input type="text"/>
	Extremely difficult	<input type="text"/>