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**Calgary SAQLI: Part 1
Calgary Sleep Apnea Quality of Life Index
(Staff)**

Directions: Please use dark marks. Fill bubbles completely. Example: ●Yes ○No

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, housework, etc.) during the previous 4 weeks:

<u>Yellow Card:</u>		4 = A moderate amount of time
1 = All the time		5 = A small to moderate amount of time
2 = A large amount of time		6 = A small amount of time
3 = A moderate to large amount of time		7 = Not at all

1.	How much have you had to force yourself to do this activity?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
2.	How much of the time have you had to push yourself to remain alert while performing this activity?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
3.	How often have you adjusted your schedule to avoid this activity because you felt you would be unable to remain alert while doing it?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
4.	How often do you use all of your energy to accomplish only this activity?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

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

Green Card:		4 = A moderate amount
1 = A very large amount		5 = A small to moderate amount
2 = A large amount		6 = A small amount
3 = A moderate to large amount		7 = None

5.	How much difficulty have you had finding the energy to exercise and/or do activities that you find relaxing (leisure activities)?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
6.	How much difficulty have you had finding the time for activities that you find relaxing?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
7.	How much difficulty have you had with your ability to do exercise and/or activities that you find relaxing?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
8.	How much difficulty have you had getting chores done around the place where you live?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

III. General functioning. During the previous 4 weeks:

Green Card:		4 = A moderate amount
1 = A very large amount		5 = A small to moderate amount
2 = A large amount		6 = A small amount
3 = A moderate to large amount		7 = None

9.	How much difficulty have you had with trying to remember things?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
10.	How much difficulty have you had with trying to concentrate?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

Red Card:		4 = A moderate problem
1 = A very large problem		5 = A small to moderate problem
2 = A large problem		6 = A small problem
3 = A moderate to large problem		7 = No problem

11.	How much of a problem have you had with having to fight to stay awake?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
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B. Social Interactions

The following questions pertain to how your relationships 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 relationships might have been with these people.

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						
1.	How upset have you been about being told that your snoring was bothersome or irritating?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
2.	How upset have you been about having to (or possibly having to) sleep in separate bedrooms from your partner?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
3.	How upset have you been as a result of frequent conflicts or arguments?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
4.	How aware have you been of not wanting to talk to other people?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
5.	How much concern have you had about the need to make special sleeping arrangements if you were traveling and/or staying with someone?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
6.	How guilty have you felt about your relationship with family members or close personal friends?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
Yellow Card: 1 = All the time 2 = A large amount of time 3 = A moderate to large amount of time		4 = A moderate amount of time 5 = A small to moderate amount of time 6 = A small amount of time 7 = Not at all						
7.	How often have you looked for excuses for being tired?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
8.	How often have you experienced wanting to be left alone?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
9.	How often have you felt like not wanting to do things together with your partner, children, and/or friends?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7



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B. Social Interactions (Continued)

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

- | | | | | | | | | |
|-----|--|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 10. | How much of a problem have you felt there is with your relationship to the person who is closest to you? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 11. | How much of a problem have you had from not being involved in family activities? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 12. | How much of a problem have you had with inadequate and/or infrequent sexual intimacy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 13. | How much of a problem have you had with a lack of interest in being around other people? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |

C. Emotional Functioning

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

Yellow Card:

- 1 = All the time
- 2 = A large amount of time
- 3 = A moderate to large amount of time

4 = A moderate amount of time

5 = A small to moderate amount of time

6 = A small amount of time

7 = Not at all

- | | | | | | | | | |
|----|--|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 1. | How often have you been feeling depressed, down, and/or hopeless? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 2. | How often have you been feeling anxious or fearful about what was wrong? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 3. | How often have you been feeling frustrated? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 4. | How often have you been feeling irritable and/or moody? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 5. | How often have you been feeling impatient? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |
| 6. | How often have you been feeling that you are being unreasonable? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 |



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C. Emotional Functioning (Continued)

Yellow Card:

1 = All the time

2 = A large amount of time

3 = A moderate to large amount of time

4 = A moderate amount of time

5 = A small to moderate amount of time

6 = A small amount of time

7 = Not at all

7. How often have you been getting easily upset?
 1 2 3 4 5 6 7

8. How often have you experienced a tendency to become angry?
 1 2 3 4 5 6 7

9. How often have you been feeling like you were unable to cope with everyday issues?
 1 2 3 4 5 6 7

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

10. How concerned have you been about your weight?
 1 2 3 4 5 6 7

11. How concerned have you been about heart problems (heart attacks or heart failure) and/or premature death?
 1 2 3 4 5 6 7



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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). Next, indicate if you have experienced those symptoms during the previous 4 weeks. Once the list is finished, please tell me any additional symptoms 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	OYes	ONo
2. Excessive fatigue	OYes	ONo
3. Feeling that ordinary activities require an effort to perform or complete	OYes	ONo
4. Falling asleep at inappropriate times or places	OYes	ONo
5. Falling asleep if not stimulated or active	OYes	ONo
6. Difficulty with a dry or sore mouth/throat upon awakening	OYes	ONo
7. Waking up often (more than twice) during the night	OYes	ONo
8. Difficulty returning to sleep if you wake up in the night	OYes	ONo
9. Concern about the times you stop breathing at night	OYes	ONo
10. Waking up at night feeling like you were choking	OYes	ONo
11. Waking up in the morning with a headache	OYes	ONo
12. Waking up in the morning feeling unrefreshed and/or tired	OYes	ONo
13. Waking up more than once per night to urinate	OYes	ONo
14. A feeling that your sleep is restless	OYes	ONo
15. Difficulty staying awake while reading	OYes	ONo
16. Difficulty staying awake while trying to carry on a conversation	OYes	ONo
17. Difficulty staying awake while trying to watch something (concert, movie, TV)	OYes	ONo
18. Fighting the urge to fall asleep while driving	OYes	ONo
19. A reluctance or inability to drive for more than 1 hour	OYes	ONo
20. Concern regarding close calls while driving due to your inability to remain alert	OYes	ONo



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D. Symptoms (Continued)

Past 4 Weeks?

21. Concern regarding your or other's safety when you're operating a motor vehicle or machinery	OYes	ONo
22. Other 1, Specify _____	OYes	ONo
23. Other 2, Specify _____	OYes	ONo

Five most important symptoms you have experienced (use numbers from above):

Red Card:		4 = A moderate problem						
1 = A very large problem		5 = A small to moderate problem						
2 = A large problem		6 = A small problem						
3 = A moderate to large problem		7 = No problem						
	Symptom	How much of a problem has it been?						
1.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
2.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
3.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
4.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
5.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

Note to Interviewer:

Baseline: End of Calgary SAQLI Part 1

Months 1 and 3: Continue with Part 2 of the Calgary SAQLI (sections E and F)

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Calgary SAQLI: Part 2 Calgary Sleep Apnea Quality of Life Index (Staff)

Directions: Please use dark marks. Fill bubbles completely. Example: ●Yes ○No

E. Treatment-Related Symptoms

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). Next, indicate if you have experienced those symptoms during the previous 4 weeks. Once the list is finished, please tell me any additional symptoms 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	OYes	ONo
2. Stuffed or congested or blocked nose	OYes	ONo
3. Excessive dryness of the nose or throat passages, especially upon awakening	OYes	ONo
4. Soreness in the nose or throat passages	OYes	ONo
5. Headaches	OYes	ONo
6. Eye irritation	OYes	ONo
7. Ear pain	OYes	ONo
8. Waking up frequently during the night	OYes	ONo
9. Difficulty returning to sleep if you awaken	OYes	ONo
10. Air leakage from the nasal mask	OYes	ONo
11. Discomfort from the nasal mask	OYes	ONo
12. Marks or rash on your face	OYes	ONo
13. Complaints from your partner about the noise of the CPAP machine	OYes	ONo
14. Having fluid/food pass into your nose when you swallow	OYes	ONo
15. A change in how your voice sounds	OYes	ONo



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16. Pain in the throat when swallowing	OYes	ONo
17. Pain or aching in your jaw joint or jaw muscles	OYes	ONo
18. Feeling self-conscious	OYes	ONo
19. Aching in your teeth that lasts at least an hour	OYes	ONo
20. Discomfort, aching, or tenderness of your gums	OYes	ONo
21. Hardship in being able to pay for the treatment	OYes	ONo
22. A sense of suffocation	OYes	ONo
23. Excessive salivation	OYes	ONo
24. Difficulty chewing in the morning	OYes	ONo
25. Difficulty chewing with your back teeth that persists most of the day	OYes	ONo
26. Movement of the teeth so that the upper and lower teeth no longer meet properly	OYes	ONo
27. Other 1, Specify_____	OYes	ONo
28. Other 1, Specify_____	OYes	ONo



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Five most important symptoms you have experienced (use numbers from above):

Red Card:		4 = A moderate problem						
1 = A very large problem		5 = A small to moderate problem						
2 = A large problem		6 = A small problem						
3 = A moderate to large problem		7 = No problem						
	Symptom	How much of a problem has it been?						
1.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
2.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
3.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
4.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
5.	<input type="text"/> <input type="text"/>	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

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. Fill in the Bubble.										
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	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?										
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10
(no impact)										(extremely large impact)