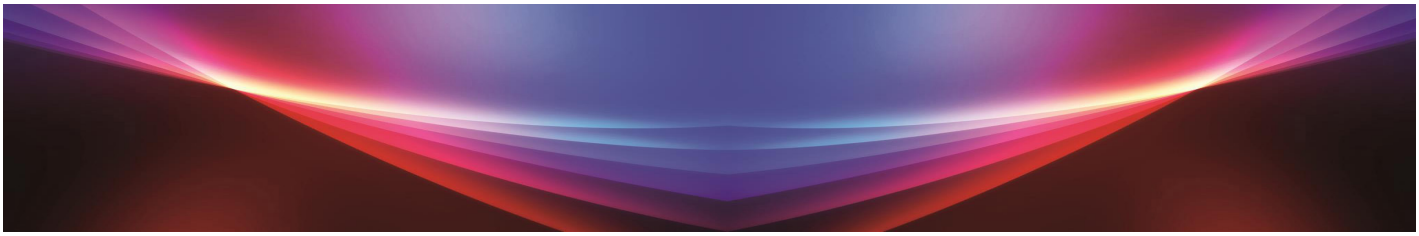

SUPPLEMENTARY MATERIAL

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Assessment of health status and its correlation with lung function in patients with chronic obstructive pulmonary disease: a study from a tertiary care center in north India

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Key words: COPD, HRQL, FeV_1.

Annexure-4

ST. GEORGE'S RESPIRATORY QUESTIONNAIRE

PART 1

Over the part 4 weeks

1. I have coughed Score

- Most days a weel
- Several days a week
- A few days a week
- Only with chest infection
- Not at all

2. I have brought up phlegm Score

- Most days a week
- Several days a week
- A few days a week
- Only with chest infection
- Not at all

3. I have has shortness of breadth Score

- Most days a week
- Several days a week
- A few days a week
- Only with chest infection
- Not at all

4. K have had attacks of wheezing Score

- Most days a week
- Several dyas a week
- A few days a week
- Only with chest infection
- Not at all

5. How many severe oer very anpleasant attacks of chest problem have you had ?

- More than 3 attacks
- 3 attacks
- 2 attacks Score
- 1 attacks
- No attacks

6. How long did the worst attack of chest problem last:

(Go to question 7 if you had no severe attacks)

- a week or more
- 3 days or more
- 1 or 2 days

- Less than a day

7. Over the past 4 weeks, in an average week, how may good days (with little chest problem) have you had:

- No good days Score
- 1 or 2 good days
- 3 or 4 good days
- Nearly every day was good
- Every day was good

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

- Yes
- No

PART-2

1. How would you describe your chest condition? Score

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

If you have ever had paid employment.

- My chest problem made me stop work all together
- My chest problem interferes with my work or made me change my work
- My chest problem dose not affect my work

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

	True	False
Sitting or lying still	□	□
Getting washed or dressed	□	□
Waling around at home	□	□
Walking outside on the level	□	□
Climbing up a flight of stairs	□	□
Climbing hills	□	□
Playing sports or games	□	□

3. Some more questions about your cough and breathlessness these days. Score

	True	False
My cough hurts	□	□
My cough makes me tired	□	□
I am breathless when I talk	□	□
I am breathless when I bend overq	□	□
My cough or Breathing disturbs my sleep	□	□
I get exhausted easily	□	□

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

	True	False	Score
My cough or breathing is embarrassing in public	□	□	
My chest problem is a nuisance ot my family, firends or neighbours	□	□	
I get afraid or panic when I cannot get my breath	□	□	
I feel that I am not in control of my chest problem	□	□	
I do not expect my chest to get any better	□	□	
I have become frail or an invalid because of my chest	□	□	
Exercise is not safe for me	□	□	
Everything seems too much of an effort	□	□	

5. Questions about your medication. If you are taking no medication go straight to section

	True	False	Score
My medication does not help me very much	□	□	
I get embarrassed using my medication in public.	□	□	
I have unpleasant side effects from my medication	□	□	
My medication interferes with my life a lot	□	□	

6. We would like to know how your chest problem usually affect your daily life.

	True	False	Score
I cannot play sports or games	□	□	
I cannot go out for entertairnment or recreation	□	□	
I cannot go out of the because to do the grocerics	□	□	
I cannot do housework	□	□	
I cannot move far from my bed or chair	□	□	

7. Not, would you checkmark the bos (one only) which you think best cescribes how your chest effects you:

	True	False	Score
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	□	□	

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

	True	False	Score
I take a long time to get washed or dressed	□	□	
I cannot take a bath or shower, or I take a long time	□	□	
I walk slower than other people, or stop for rests	□	□	
Jobs such as bouse work take a long time, or I have to stop for rests	□	□	
If I walk up one flight of stairs, I bave to go slowly or stop	□	□	
If I Hurry or walk fast, I have to stop or slow down	□	□	
My breathing makes it difficuts to do	□	□	
Things such as climbing up hills, carrying	□	□	
Things up stairs, light gardening such as weeding, dancing,	□	□	

playing bowls or golf		
My breathing makes it difficult to do things such as	☐	☐
Carrying heavy loads,		
Digging the garden or shovelling snow, jogging or walking	☐	☐
At 8 Kilometres per hour, playing tennis or swimming	☐	☐
My breathing makes it difficult to do things such as	☐	☐
Very heavy mantal work,		
Running cycling, swimming fast or playing competitive sports	☐	☐

Total Score:

Annexure-5

COPD AND ASTHMA SLEEP IMPACT SCALE (CASIS)

SEVEN ITEMS :-

Score

1. Nocturnal symptoms (i.e. coughing, difficulty breathing etc.).
2. Trouble falling and remaining asleep.
3. Waking during the night.
4. Disturbed sleep.
5. Feeling tired.
6. Not rested when waking-up.
7. Worsening respiratory symptoms during the night.

Total Score:

Scoring System

1	2	3	4	5

1 = never.

2 = few days a month

3 =several days a week

4= most days a week

5 = Very often.

Recall time period for the measure will be previous week, with higher scores indicating greater sleep impairment.0

Annexure-6

FUNCTIONAL PERFORMANCE INVENTORY-SHORT FORM

For each item/activity, respondents are asked to rate how difficult the activity is for them to perform on a simple three-point scale: "no difficulty," "some difficulty", or "much difficulty". If respondents do not perform an activity, they can select one of two options: "don't do for health reasons" or "choose not to."

Body care	DO with ...			DON'T DO because ...	
	No difficulty	Some difficulty	Much difficulty	Health reasons	Choose not to
Dressing and undressing	3	2	1		
Showering or bathing	3	2	1		
Caring for your feet	3	2	1		
Washing your hair	3	2	1		
Shaving or applying makeup	3	2	1		

Figure Presentation format for the FPI-SF.
Notes: Illustration presents one of six domains comprising the FPI-SF.
Abbreviation: FPI-SF, Functional Performance Inventory-Short Form.

SIX DOMAINS :-

1. **BODY CARE :** Score :
   - Dressing and undressing.
   - Showering and bathing.
   - Caring for your feet.
   - Washing your hair.
   - Shaving or applying makeup.

2 **MAINTAINING THE HOUSEHOLD** Score

Groceries and meals

- Preparing meals / cooking.
- Grocery shopping.
- Carrying Groceries

Activities around the house or Apartment

- Vacuuming or sweeping.

- Moving furniture, changing sheets or washing windows, yardwork, laundry.

Going to appointments (such as Doctors or Dentists)

3. **PHYSICAL EXERCISE** Score

- Regular stretching, moving or lifting light weights.
- Walking up and down a flight of stairs.
- Short walks around the neighbourhood or mall.
- Long fast walks (more than 20 minutes)
- Activities such as swimming or bicycling.

4 **RECREATION : ACTIVITIES FOR PERSONAL PLEASURE** Score

- Taking vacations.
- Activities away from the house or apartments.
- Indoor activities such as shopping or museums.
- Going to the movies.
- Activities around the house or apartment.
- Sitting outside.
- Reading

5. **SPIRITUAL ACTIVITIES** Score

- Attending religious services.
- Going to religious ceremonies.
- Personal reading, meditation or prayer.
- Visits from spiritual friends or teachers.

6. **SOCIAL INTERACTIONS : FAMILY AND FRIENDS** Score

- Dinner, cards, bingo or other activity: in your home.
- Going to store, giving rids, doing repairs or other favors
- Helping in the care of children.
- Distant or overnight travel to visit others.

Total Score:

Annexure-7

COPD AND ASTHMA FATIGUE SCALE (CAFS)

TWELVE ITEMS :-

Score

1. Avoid activities because you did not have the energy?
2. Feel exhausted?
3. Not finish a task you started because you were too tired?
4. Plan your day around your fatigue?
5. Feel too tired to do your daily activities or things around the house?
6. Need to rest during the day?
7. Feel too exhausted to leave your house?
8. Have to pace yourself?
9. Feel too tired to think clearly?
10. Feel tired?
11. Feel full of energy?
12. Does not have the energy to complete your daily activities?

Total Score:

Scoring System

1	2	3	4	5

1 = never.

2 = few days a month

3 =several days a week

4= most days a week

5 = Very often.

Scores linearly transformed to 0–100 total scale score with higher scores indicating greater fatigue. The recall time period for the measure will be previous week.