Sleep Apnea Quality of Life Index (Flemons & Reimer, 1998) Version translated and adapted by Sampaio, Pereira & Winck, 2008

This questionnaire was designed to understand how have you been and how you have felt over the LAST 4 WEEKS. You will be questioned about the impact your sleep apnea/snoring has had on your daily activities, emotional functioning and social interactions, and about any symptoms that may have been the cause.

A. Daily Functioning

1. Very big (□&●), All The Time (●)
2. Large
3. Moderate to Large
4. Moderate
5. Small to Moderate
6. Small
7. No (□) None (V) None (●)

□- Problem
●- Quantity
●-Amount of Time

I. Most Important Daily Activities

1. How much EFFORT HAVE YOU HAD TO MAKE TO PERFORM THIS ACTIVITY?

2. How much time have you spent to REMAIN AWAKE/ALERT WHILE YOU PERFORMED THIS ACTIVITY?

3. How often have you ADJUSTED YOUR SCHEDULE TO AVOID THIS ACTIVITY BECAUSE YOU FELT YOU WOULD BE INCAPABLE OF STAYING AWAKE WHILE PERFORMING IT?

4. How often do you USE ALL YOUR ENERGY JUST TO COMPLETE THIS ACTIVITY?

II. Secondary Activities

5. What degree of difficulty have you experienced in GAINING THE ENERGY TO PERFORM PHYSICAL EXERCISE OR ACTIVITIES YOU CONSIDER RELAXING (LEISURE ACTIVITIES)?

6. What degree of difficulty have you experienced in FINDING THE TIME FOR ACTIVITIES YOU CONSIDER RELAXING (LEISURE ACTIVITIES)?

7. What degree of difficulty have you experienced in WITH YOUR ABILITY TO PERFORM PHYSICAL EXERCISE AND/OR ACTIVITIES YOU CONSIDER RELAXING?

8. What degree of difficulty have you experienced in PERFORMING TASKS AT HOME?

III. General Functioning

9. What degree of difficulty have you experienced in TRYING TO REMEMBER THINGS?

10. What degree of difficulty have you experienced in TRYING TO CONCENTRATE?

11. How difficult has it been to STRUGGLE TO STAY AWAKE?
B. Social Interactions

1. Very Large (□) & ○, All the time (●)
2. Large
3. Moderate to Large
4. Moderate
5. Small to Moderate
6. Small
7. No (□) None (●) None (●)

☐ - Problem
○ - Quantity
● - Amount of Time

1. How bothered have you been TO HEAR THAT YOUR SNORING IS DISRUPTIVE OR IRRITATING?

2. How bothered have you been to have to (or possibly have to) SLEEP IN A SEPARATE ROOM FROM YOUR PARTNER?

3. How bothered have you been with FREQUENT CONFLICTS OR ARGUMENTS?

4. How aware have you been of NOT WANTING TO TALK TO OTHER PEOPLE?

5. How worried do you feel UPON THE NEED TO PLAN ACCOMMODATIONS DURING A TRIP AND/OR STAYING IN ANOTHER PERSON'S HOME?

6. How guilty do you feel about your relationship WITH OTHER FAMILY MEMBERS OR CLOSE FRIENDS?

7. How often have you SOUGHT EXCUSES FOR BEING TIRED?

8. How often have you FELT THE DESIRE TO BE LEFT ALONE?

9. How often have you felt A LACK OF MOTIVATION TO DO THINGS WITH YOUR PARTNER, CHILDREN AND/OR FRIENDS?

10. How problematic is the RELATIONSHIP YOU HAVE WITH THE PERSON CLOSEST TO YOU?

11. How problematic has the fact that YOU ARE NOT INVOLVED IN FAMILY ACTIVITIES BEEN?

12. How problematic has it been to have INADEQUATE AND/OR INFREQUENT SEXUAL RELATIONS?

13. How problematic has the DECREASE IN INTEREST TO BE WITH OTHER PEOPLE BEEN?
### C. Emotional Functioning

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<td>Very Large (☐ &amp; ●) At all times (□)</td>
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- Problem
- Quantity
- Quantity of Time

1. How often have you felt DEPRESSED, DOWN AND/OR HOPELESS? ²
2. How often have you felt ANXIOUS OR FEARFUL ABOUT WHAT IS HAPPENING TO YOU? ³
3. How often have you felt FRUSTRATED? ⁴
4. How often have you felt ANGRY AND/OR GRUMPY? ⁵
5. How often have you felt IMPATIENT? ⁶
6. How often have you felt THAT YOU ARE BEING INAPPROPRIATE? ⁷
7. How often have you been EASILY ANNOYED? ⁸
8. How often have you experienced a tendency to GET ANGRY? ⁹
9. How often have felt that YOU ARE UNABLE TO DEAL WITH EVERYDAY ISSUES? ¹⁰
10. How concerned have you been about YOUR WEIGHT? ¹¹
11. How concerned you have been about the possibility of SUFFERING FROM HEART PROBLEMS (HEART ATTACKS OR HEART FAILURE) AND/OR PREMATURE DEATH? ¹²

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D. Symptoms

Below is a list of symptoms that some people with sleep apnea and/or snoring may experience. Throughout the list circle the symptoms you have experienced during the LAST 4 WEEKS. Blank spaces are included at the end of the list to add other symptoms not included in the list. When you finish choose the 5 most significant symptoms you experienced and identify how problematic each has been.

1. Decreased energy
2. Excessive fatigue
3. Feeling that everyday activities require extra effort to perform or complete
4. Falling asleep at inappropriate times and places
5. Falling asleep when not stimulated or active
6. Difficulty with dry or sore mouth/throat upon waking up
7. Waking up several times (more than twice) during the night
8. Difficulty in going back to sleep after waking up at night
9. Concern about the times you stop breathing during the night
10. Waking at night with the feeling that you are suffocating
11. Waking up in the morning with headaches
12. Waking up in the morning feeling tired.
13. Waking up more than once during the night (on average) to urinate
14. Feeling that your sleep is not restful
15. Difficulty staying awake when you are reading
16. Difficulty staying awake during a conversation
17. Difficulty staying awake while trying to watch something (e.g. a concert, theater, film, cinema, TV programs)
18. Fighting drowsiness while driving
19. Reluctance or inability to drive for more than 1 hour.
20. Worrying about being alert and reacting during situations caused wholly or partly by an inability to stay awake while driving
21. Concern for your safety and that of others when you are driving motor vehicles and/or machines.
22. ________________________________________________________________
23. ________________________________________________________________
24. ________________________________________________________________

**Selection of Symptoms**

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E. Treatment-related symptoms
(Complete this section only if the patient has received some kind of therapy for sleep apnea and/or snoring)

Below is a list of symptoms that some people with sleep apnea and/or snoring may experience. Throughout the list circle the symptoms you have experienced during the LAST 4 WEEKS. Blank spaces are included at the end of the list to add other symptoms not included in the list. When you finish choose the 5 most significant symptoms you experienced and identify how problematic each has been.

1. Runny nose
2. Stuffed-up, congested or mucous-filled nose
3. Excessive dryness of the nose or throat especially upon waking up
4. Painful sensation with the passage of air into the nose or throat
5. Headaches
6. Eye irritation
7. Earaches
8. Waking up several times during the night
9. Difficulty returning to sleep after waking up
10. Air leak in the nasal mask
11. Discomfort caused by the mask
12. Marks or redness on the face
13. Complaints from your partner about the CPAP noise
14. Food passing through the nasal passages when swallowing
15. Change in your tone of voice
16. Throat pain upon swallowing that lasts at least 1 hour
17. Mild or acute pain at the attachment site or jaw muscles
18. Feeling aware of your problem
19. Pain in the teeth lasting at least 1 hour
20. Discomfort, pain or drowsiness in the gums
21. Difficulty in paying for treatment
22. Feeling of suffocation
23. Drooling
24. Difficulty chewing in the morning
25. Difficulty in chewing with the back teeth lasting throughout most of the day
26. Shifting of the teeth such that the upper and lower teeth no longer properly meet
27. 
28. 

Selected Symptoms

|   | a.                                                                dağdaa 1 2 3 4 5 6 7 |
|---|--------------------------------------------------------------------|----------------------------|
| b. |                                                                dağdaa 1 2 3 4 5 6 7 |
| c. |                                                                dağdaa 1 2 3 4 5 6 7 |
| d. |                                                                dağdaa 1 2 3 4 5 6 7 |
| e. |                                                                dağdaa 1 2 3 4 5 6 7 |

F. Impact
Do not complete this section if you have not received treatment for sleep apnea over the last 4 weeks.

I. Daily Functioning, Social Interaction, Emotional Functioning, Symptoms

Please consider the questions in sections A, B, C and D. As you are receiving treatment for your Sleep Apnea, do you believe that your quality of life has improved since starting treatment?

Yes

No

If Yes, what impact has it had on your life? (Please write on the line)

0 10

No Impact  Major Impact

II – Treatment-related symptoms

Please consider the symptoms that occurred as a result of treatment for your sleep apnea (Section E). What impact have these symptoms had on your life? (Please write on the line)

0 10

No Impact  Major Impact