APPENDIX D – Calgary Sleep Apnea Quality of Life Index (SAQLI)
This questionnaire has been designed to find out how you have been doing and feeling over the last 4 wk. 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 wk:

1. How much have you had to force yourself to do this activity? [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

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

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]

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

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

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

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

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

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

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

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

9. How much difficulty have you had with trying to remember things? [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 much difficulty have you had with trying to concentrate? [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

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

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 wk. If you have not interacted with a partner, etc. in the previous 4 wk, 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]

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

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

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

4. How aware have you been of not wanting to talk to other 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

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]

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

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

7. How often have you looked for excuses for being tired? [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

8. How often have you experienced wanting to be left alone?

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

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

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

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

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

C. Emotional Functioning
With respect to how you have been feeling inside during the previous

4 wk:

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

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

3. How often have you been feeling frustrated? [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

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

5. How often have you been feeling impatient? [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

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

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

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

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

10. How concerned have you been about your weight? [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

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

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. [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

1. Decreased energy
2. Excessive fatigue
3. Feeling that ordinary activities require an extra effort to perform or complete
4. Falling asleep at inappropriate times or places
5. Falling asleep if not stimulated or active
6. Difficulty with a dry or sore mouth/throat upon awakening
7. Waking up often (more than twice) during the night

8. Difficulty returning to sleep if you wake up in the night
9. Concern about the times you stop breathing at night
10. Waking up at night feeling like you were choking
11. Waking up in the morning with a headache
12. Waking up in the morning feeling unrefreshed and/or tired
13. Waking up more than once per night to urinate
14. A feeling that your sleep is restless
15. Difficulty staying awake while reading
16. Difficulty staying awake while trying to carry on a conversation
17. Difficulty staying awake while trying to watch something (concert, movie, TV)
18. Fighting the urge to fall asleep while driving
19. A reluctance or inability to drive for > 1 h
20. Concern regarding close calls while driving due to your inability to remain alert
21. Concern regarding your or other's safety when you're operating a motor vehicle or machinery
22. _____
23. _____

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 wk. 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. [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

1. Runny nose
2. Stuffed or congested or blocked nose
3. Excessive dryness of the nose or throat passages, especially upon awakening
4. Soreness in the nose or throat passages
5. Headaches
6. Eye irritation
7. Ear pain
8. Waking up frequently during the night
9. Difficulty returning to sleep if you awaken

10. Air leakage from the nasal mask
11. Discomfort from the nasal mask
12. Marks or rash on your face
13. Complaints from your partner about the noise of the CPAP machine
14. Having fluid/food pass into your nose when you swallow
15. A change in how your voice sounds
16. Pain in the throat when swallowing
17. Pain or aching in your jaw joint or jaw muscles
18. Feeling self conscious
19. Aching in your teeth that lasts at least an hour
20. Discomfort, aching, or tenderness of your gums
21. Hardship in being able to pay for the treatment
22. A sense of suffocation
23. Excessive salivation
24. Difficulty chewing in the morning
25. Difficulty chewing with your back teeth that persists most of the day
26. Movement of the teeth so that the upper and lower teeth no longer meet properly
27. _____
28. _____

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

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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