

SMOKING CESSATION QUALITY OF LIFE (SCQoL) QUESTIONNAIRE

INSTRUCTIONS: This questionnaire asks for your views about your health and well being. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

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1. In general, would you say your health is:

Excellent

Very Good

Good

Fair

Poor

2. **Compared to one year ago**, how would you rate your health in general **now**?

Much better
now than one
year ago

Somewhat better
now than one
year ago

About the
same as one
year ago

Somewhat worse
now than one
year ago

Much worse now
than one year ago

3. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a) <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Climbing <u>several</u> flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Climbing <u>one</u> flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Bending, kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Walking <u>more than a mile</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Walking <u>several blocks</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Walking <u>one block</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the **past week**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	YES	NO
a) Cut down on the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b) <u>Accomplished less</u> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c) Were limited in the <u>kind</u> of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
d) Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

5. During the **past week**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	YES	NO
a) Cut down the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b) <u>Accomplished less</u> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c) Didn't do work or other activities <u>as carefully as usual</u>	<input type="checkbox"/>	<input type="checkbox"/>

6. During the **past week**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How much **bodily** pain have you had during the **past week**?

None	Very mild	Mild	Moderate	Severe	Very severe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. During the **past week**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. These questions are about how you feel and how things have been with you **during the past week**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past week**. . .

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a) Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the **past week**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I seem to get sick a little easier than other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am as healthy as anybody I know.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I expect my health to get worse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My health is excellent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. These questions are about how you feel and how things have been going during the **past week**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past week**...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Did you act irritable toward those around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Did you get along well with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Did you have difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Were you obsessed by thoughts of smoking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Did you have difficulty thinking and solving problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Did you feel restless, unsettled or jittery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Did you feel anxious or worried?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Did you have difficulty remembering things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How often **during the past week** did you...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Have trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Awaken during the night and have trouble falling asleep again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Get the amount of sleep you needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I have very little willpower in regard to smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am in control of whether I smoke or not.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am worried that I will smoke in the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) The urge to smoke overwhelms me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>