Quality of Life in Essential Tremor Questionnaire (QUEST)

Patient's Name: _____ ID: _____ Date: ____/____/____

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____

Heath Status

In general, how would you rate your overall health? (0=very poor health, 100=excellent/perfect health)

Circle: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Overall Quality of Life

Overall, how would you rate your quality of life? (0=very poor health, 100=excellent/perfect health)

Circle: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

General Information

In the past month, has your tremor interfered with your sexual satisfaction?	Y	N
In the past month, have you had side effects from tremor medications?	Y	N
In the past month, have you been satisfied with the tremor control achieved by your medications?	Y	N

Which most appropriately describes your work status?

- ☐ Never worked
- ☐ Not working, retired because of tremor
- ☐ Not working, retired NOT due to tremor
- ☐ Working full time
- ☐ Working part time

TREMOR SELF ASSESSMENT

For the purposes of this questionnaire, tremor is defined as uncontrollable shaking or quivering of the body part in question.

On a typical day, how many of your waking hours do you have tremor in ANY body part?

Circle: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Put a mark in the box to rate the severity of your tremor in each of the body parts listed below.

None - no tremor at any time
Mild - mild tremor not causing difficulty in performing any activities
Moderate - tremor causes difficulty in performing **some** activities
Marked - tremor causes difficulty in performing **most** or **all** activities
Severe - tremor **prevents** performing some activities

		None	Mild	Moderate	Marked	Severe
1.	Head	☐	☐	☐	☐	☐
2.	Voice	☐	☐	☐	☐	☐
3.	Right arm/hand	☐	☐	☐	☐	☐
4.	Left arm/hand	☐	☐	☐	☐	☐
5.	Right leg/foot	☐	☐	☐	☐	☐
6.	Left leg/foot	☐	☐	☐	☐	☐

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For each question below, please mark the box which best describes your current situation.

For example: N R ~~S~~ F A

N = Never/No
R = Rarely
S = Sometimes
F = Frequently
A = Always/Yes
NA = Not Applicable

1.	My tremor interferes with my ability to communicate with others.		N	R	S	F	A
2.	My tremor interferes with my ability to maintain conversations with others.		N	R	S	F	A
3.	It is difficult for others to understand my speech because of my tremor.		N	R	S	F	A
4.	My tremor interferes with my job or profession.	NA	N	R	S	F	A
5.	I have had to change jobs because of my tremor.	NA	N	R	S	F	A
6.	I had to retire or take early retirement because of my tremor.		N				A
7.	I am only working part time because of my tremor.	NA	N				A
8.	I have had to use special aids or accommodations in order to continue my job due to my tremor.	NA	N	R	S	F	A
9.	My tremor has led to financial problems or concerns.		N	R	S	F	A
10.	I have lost interest in my hobbies because of my tremor.		N	R	S	F	A
11.	I have quit some of my hobbies because of my tremor.		N				A
12.	I have had to change or develop new hobbies because of my tremor.		N				A
13.	My tremor interferes with my ability to write (for example, writing letters, completing forms).		N	R	S	F	A
14.	My tremor interferes with my ability to use a typewriter or computer.	NA	N	R	S	F	A
15.	My tremor interferes with my ability to use the telephone (for example, dialing, holding the phone).		N	R	S	F	A
16.	My tremor interferes with my ability to fix small things around the house (for example, change light bulbs, minor plumbing, fixing household appliances, fixing broken items).		N	R	S	F	A
17.	My tremor interferes with dressing (for example, buttoning, zipping, tying shoes).		N	R	S	F	A
18.	My tremor interferes with brushing or flossing my teeth.		N	R	S	F	A
19.	My tremor interferes with eating (for example, bringing food to mouth, spilling).		N	R	S	F	A
20.	My tremor interferes with drinking liquids (for example, bringing to mouth, spilling, pouring).		N	R	S	F	A
21.	My tremor interferes with reading or holding reading material.		N	R	S	F	A
22.	My tremor interferes with my relationships with others (for example, my family, friends, coworkers).		N	R	S	F	A
23.	My tremor makes me feel negative about myself.		N	R	S	F	A
24.	I am embarrassed about my tremor.		N	R	S	F	A
25.	I am depressed because of my tremor.		N	R	S	F	A
26.	I feel isolated or lonely because of my tremor.		N	R	S	F	A
27.	I worry about the future due to my tremor.		N	R	S	F	A
28.	I am nervous or anxious.		N	R	S	F	A
29.	I use alcohol more frequently than I would like to because of my tremor.		N	R	S	F	A
30.	I have difficulty concentrating because of my tremor.		N	R	S	F	A

THANK YOU!

Patient Name: _____ DOB: _____ Today's Date: _____

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it **during the past month.** The doctor or nurse may ask you some questions to help decide. If you have **not** experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

	Yes	No
1. Dribbling of saliva during the daytime	☐	☐
2. Loss or change in your ability to taste or smell	☐	☐
3. Difficulty swallowing food or drink or problems with choking	☐	☐
4. Vomiting or feelings of sickness (nausea)	☐	☐
5. Constipation (less than 3 bowel movements a week) or having to strain to pass a stool (faeces)	☐	☐
6. Bowel (fecal) incontinence	☐	☐
7. Feeling that your bowel emptying is incomplete after having been to the toilet	☐	☐
8. A sense of urgency to pass urine makes you rush to the toilet	☐	☐
9. Getting up regularly at night to pass urine	☐	☐
10. Unexplained pains (not due to known conditions such as arthritis)	☐	☐
11. Unexplained change in weight (not due to change in diet)	☐	☐
12. Problems remembering things that have happened recently or forgetting to do things	☐	☐
13. Loss of interest in what is happening around you or doing things	☐	☐
14. Seeing or hearing things that you know or are told are not there	☐	☐
15. Difficulty concentrating or staying focussed	☐	☐
16. Feeling sad, 'low' or 'blue'	☐	☐
17. Feeling anxious, frightened or panicky	☐	☐
18. Feeling less interested in sex or more interested in sex	☐	☐
19. Finding it difficult to have sex when you try	☐	☐
20. Feeling light headed, dizzy or weak standing from sitting or lying	☐	☐
21. Falling	☐	☐
22. Finding it difficult to stay awake during activities such as working, driving or eating	☐	☐
23. Difficulty getting to sleep at night or staying asleep at night	☐	☐
24. Intense, vivid dreams or frightening dreams	☐	☐
25. Talking or moving about in your sleep as if you are 'acting' out a dream	☐	☐
26. Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move	☐	☐
27. Swelling of your legs	☐	☐
28. Excessive sweating	☐	☐
29. Double vision	☐	☐
30. Believing things are happening to you that other people say are not true	☐	☐

Patient Name: _____ DOB: _____ Today's Date: _____