Validation of the Arabic Severe Respiratory Insufficiency Questionnaire

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Part I: General Information			
SD1	Gender	**1**	Male
		2	Female
SD2	Age	Age at last birthday	[__[__] yrs
		Date of birth (year only)	[_[_[_[_]
SD3	What is your highest educational level?	**1**	Illiterate
		2	Read and write
		3	Elementary
		4	Intermediate
		5	Secondary
		6	University
		7	Post graduate
		8	Other, specify: ----------
SD4	What is your current occupational status	**1**	Housewife
		2	Retired
		3	Not working (looking for a job)
		4	Disabled
		5	Employee (full time)
		6	Employee (part time)
		7	Self employed)
		8	Other, specify: ----------
SD5	What is you marital status?	**1**	Single

		2	Married
		3	Widowed
		4	Separated/Divorced
SD6	What is your current smoking status?	**0**	None-smoker (never smoked before) **(If selected, skip to SD15)**
		1	Ex-smoker (had smoked at least one cigarette/session of water pipe per day for at least six months but had quit).
		2	Current smoker (smoke at least one cigarette or one session of water pipe per day).
SD7	How many packs of cigarettes do you currently smoke per day?	**0**	Not applicable
		1	Pack: ----------
SD8	At which age did you start smoking cigarettes?	**0**	Not applicable
		1	**[__[__] yrs**
SD9	If you are an ex cigarette smoker, at which age did you stop smoking?	**0**	Not applicable
		1	**[__[__] yrs**
SD10	If you are an ex cigarette smoker, how many packs did you use to smoke per day?	**0**	Not applicable
		1	Pack: ----------
SD11	How many waterpipe sessions do you currently smoke per day?	**0**	Not applicable
		1	Sessions: ----------
SD12	At which age did you start smoking waterpipe?	**0**	Not applicable
		1	**[__[__] yrs**
SD13	If you are an ex waterpipe smoker, at which age did you stop smoking?	**0**	Not applicable
		1	**[__[__] yrs**
SD14	If you are an ex waterpipe smoker, how many sessions did you use to smoker per day?	**0**	Not applicable
		1	Sessions: ----------
SD15	Who lives with you at the home?	**A**	I live alone □ No = 0 □ Yes = 1
		B	My spouse □ No = 0 □ Yes = 1
		C	My child/children

			□ No = 0 □ Yes = 1
		D	My daughter-son in law □ No = 0 □ Yes = 1
		E	Other relatives □ No = 0 □ Yes = 1
		F	A maid □ No = 0 □ Yes = 1
		G	A nurse □ No = 0 □ Yes = 1
SD16	Who takes care of you at home? **(help you in daily life duties)**	**A**	Nobody □ No = 0 □ Yes = 1
		B	My spouse □ No = 0 □ Yes = 1
		C	My child/children □ No = 0 □ Yes = 1
		D	My daughter-son in law □ No = 0 □ Yes = 1
		E	Other relatives □ No = 0 □ Yes =
		F	A maid □ No = 0 □ Yes = 1
		G	A nurse □ No = 0 □ Yes = 1
SD17	Who of the above most takes care of you?	Specify: …….	
SD18	How would you rate your health compared to other people of the same age?	**1**	Much worse
		2	Worse
		3	Same
		4	Better
		5	Much better
SD19		**A**	NSSF □ No = 0 □ Yes = 1

	How are you covering the expenses of the therapy? **(the mechanical ventilation machine and supplemental oxygen)**	**B**	Cooperative of Government Employees □ No = 0 □ Yes = 1
		C	Army/police □ No = 0 □ Yes = 1
		D	Ministry of public health □ No = 0 □ Yes = 1
		E	Private insurance □ No = 0 □ Yes = 1
		F	Self payer □ No = 0 □ Yes = 1
		G	Other

Part II. Medical history

MH1	What is the underlying diagnoses leading to your respiratory failure?	**A**	COPD □ No = 0 □ Yes = 1
		B	Kyphoscoliosis □ No = 0 □ Yes = 1
		C	Neuromuscular disease □ No = 0 □ Yes = 1
		D	Obesity-hypoventilation syndrome □ No = 0 □ Yes = 1
		E	Other, specify: ----------
MH2	What is the main indication for the initiation of home mechanical ventilation?	**A**	Low oxygen saturation even after using supplemental oxygen □ No = 0 □ Yes = 1

		B	High carbon dioxide levels □ No = 0 □ Yes = 1
		C	Dyspnea during night □ No = 0 □ Yes = 1
		D	Apnea during night □ No = 0 □ Yes = 1
		E	Other, specify: ----------
MH3	How many times did you visit the emergency room during the previous year because of respiratory problems?	[__ [__] Times	
MH4	How many times were you admitted to the hospital during the previous year because of respiratory problems?	[__ [__] Times	
MH5	Have you ever been diagnosed with any of these diseases?	**A**	Hypertension □ No = 0 □ Yes = 1
		B	Diabetes □ No = 0 □ Yes = 1
		C	Renal diseases □ No = 0 □ Yes = 1
		D	Obesity □ No = 0 □ Yes = 1
		E	Sleep apnea □ No = 0 □ Yes = 1

		F	Depression □ No = 0 □ Yes = 1
		G	Other, specify: ----------
MH6	How do you rate your physical activity?	**1**	Unrestricted normal activity
		2	Restrictions on strenuous activity, able to perform undemanding tasks
		3	Very restricted everyday activity but capable of self-care
		4	Very restricted everyday activity and incapable of self-care
		5	Confined to bed/armchair, incapable of self-care
MH7	Have you had headaches during the previous week?	**0**	No
		1	Yes
MH8	Have you had daytime sleepiness during the previous week?	**0**	No
		1	Yes

Part III. Home Mechanical Ventilation

MV1	When did you start using the therapy at home (what year)?	Year [_[_][_[_]	
MV2	How long have you been using the therapy at home (for how many years)?	[_[_][_[_] years	
MV3	When do you apply the machine?	**1**	Only during the day
		2	Only during the night
		3	During the day and the night

MV4	How many hours do you use the machine **during the day**?	Specify in hours: -----------
MV5	How many hours do you use the machine **during the night**?	Specify in hours: -----------