

# Quality of Life in Essential Tremor Questionnaire (QUEST)

Patient's Name: \_\_\_\_\_ ID: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender:  Male  Female

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Health 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Right arm/hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Left arm/hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Right leg/foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Left leg/foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

continued on next page

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

For example:  N  R  S  F  A

N = Never  
 R = Rarely  
 S = Sometimes  
 F = Frequently  
 A = Always  
 NA = Not Applicable

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

NA  
 NA

NA

NA

NA

N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N			
N			

N	R	S	F
N	R	S	F
N	R	S	F
N			
N			

N	R	S	F
N	R	S	F

N	R	S	F
---	---	---	---

N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F

N	R	S	F
N	R	S	F

N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F
N	R	S	F

**THANK YOU!**

\_\_\_ / \_\_\_

\_\_\_ / \_\_\_

**vere**


