

# 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"/>				
2. Voice	<input type="checkbox"/>				
3. Right arm/hand	<input type="checkbox"/>				
4. Left arm/hand	<input type="checkbox"/>				
5. Right leg/foot	<input type="checkbox"/>				
6. Left leg/foot	<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/No  
 R = Rarely  
 S = Sometimes  
 F = Frequently  
 A = Always/Yes  
 NA = Not Applicable

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

**THANK YOU!**

# QUEST Scoring

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**If a question is Not Applicable, "X" through NA and leave blank--do not assign a score of 0.**

Scoring algorithm: $\frac{\text{Total applicable points for each dimension}}{\text{Total possible points (\# of applicable questions x 4) for each dimension}} \times 100 = \text{dimension score}$
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**N=0 R=1 S=2 F=3 A=4 NA=blank Note: Questions 6, 7, 11, & 12--0 OR 4 points possible (if applicable).**

## Communication

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. \_\_\_\_\_

## Work and Finances

4. My tremor interferes with my job or profession. NA \_\_\_\_\_
5. I have had to change jobs because of my tremor. NA \_\_\_\_\_
6. I had to retire or take early retirement because of my tremor. \_\_\_\_\_
7. I am only working part time because of my tremor. NA \_\_\_\_\_
8. I have had to use special aids or accommodations in order to continue my job due to my tremor. NA \_\_\_\_\_
9. My tremor has led to financial problems or concerns. \_\_\_\_\_

## Hobbies and Leisure

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. \_\_\_\_\_

## Physical

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. NA \_\_\_\_\_
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. \_\_\_\_\_

## Psychosocial

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. \_\_\_\_\_