

DERMATOLOGY LIFE QUALITY INDEX

DLQI

Hospital No:

Date:

Score:

Name:

Diagnosis:

Address:

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK. Please check one box for each question.

1.	Over the last week, how itchy, sore, painful or stinging has your skin been?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
2.	Over the last week, how embarrassed or self conscious have you been because of your skin?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
3.	Over the last week, how much has your skin interfered with you going shopping or looking after your home or yard ?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
4.	Over the last week, how much has your skin influenced the clothes you wear?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
5.	Over the last week, how much has your skin affected any social or leisure activities?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
6.	Over the last week, how much has your skin made it difficult for you to do any sport ?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
7.	Over the last week, has your skin prevented you from working or studying ?	yes no	<input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
	If "No", over the last week how much has your skin been a problem at work or studying ?	A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
8.	Over the last week, how much has your skin created problems with your partner or any of your close friends or relatives ?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
9.	Over the last week, how much has your skin caused any sexual difficulties ?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>
10.	Over the last week, how much of a problem has the treatment for your skin been, for example by making your home messy, or by taking up time?	Very much A lot A little Not at all	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not relevant <input type="checkbox"/>

Please check you have answered EVERY question. Thank you.