

**FORM 6a : 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 tick one box for each question.**

1.	Over the last week, how <b>itchy, sore, painful</b> or <b>stinging</b> 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 <b>embarrassed</b> or <b>self conscious</b> 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 <b>shopping</b> or looking after your <b>home</b> or <b>garden</b> ?	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 <b>clothes</b> 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 <b>social</b> or <b>leisure</b> 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 <b>sport</b> ?	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 <b>working</b> or <b>studying</b> ?	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 <b>work</b> or <b>studying</b> ?	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 <b>partner</b> or any of your <b>close friends</b> or <b>relatives</b> ?	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 <b>sexual difficulties</b> ?	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 <b>treatment</b> 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.**