

DERMATOLOGY LIFE QUALITY INDEX

DLQI

Hospital No:

Date:

Name:

Score:

Address:

Diagnosis:

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

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

Please check you have answered EVERY question. Thank you.