Questionnaire for the assessment of itch

1) Are you currently experiencing itching? □ Yes □ No (If not, do NOT complete the rest of the questionnaire)

2) Are you presenting in our practice today because you are experiencing itching? □ Yes □ No

3) Since when are you experiencing itching? □ less than 6 weeks □ more than 6 weeks

4) How severe is your itching? Please tick one box. 0= no itching; 10= very severe itching

5a) How often are you experiencing itching on average on a day (including day and night)?
   □ permanent □ almost permanent □ frequently □ seldom

5b) How much does itching affect your daily life (e.g. daily routine, profession, family)?
   □ 0= not at all □ 1= slightly □ 2= moderately □ 3= severely

6) How much does itching bother you emotionally (e.g. distressed, on edge)?
   □ 0= not at all □ 1= slightly □ 2= moderately □ 3= severely

7) How much does itching disturb your sleep?
   □ 0= not at all □ 1= slightly □ 2= moderately □ 3= severely

8) Have you ever consulted your general practitioner because of itching? □ Yes □ No

9) Has your itching been treated previously? □ Yes □ No

If yes: □ Bought creme/ointment myself □ Creme/ointment was prescribed
       □ Bought tablets myself □ Tablets were prescribed

10) Please mark the precise location of your itching.
    Please tick all the regions where you feel itchy.

   □ ( ) - Face
   □ ( ) - Throat/Neck
   □ ( ) - Back
   □ ( ) - Chest, Belly
   □ ( ) - Anogenital
   □ ( ) - Scalp
   □ ( ) - Arms
   □ ( ) - Hands
   □ ( ) - Legs
   □ ( ) - Feet

Fig. S1. English translation of the questionnaire used for the patients’ assessment of itch.