

DIZZINESS HANDICAP INVENTORY

Patient Name _____

Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 but <4 per month (3) more than one per week
 2. My dizziness/unsteadiness is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness/unsteadiness. Please check off "YES", "SOMETIMES" or "NO" to each item. Answer each question as it pertains to your dizziness/unsteadiness only.

YES	SOMETIMES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P1. Does looking up increase your problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E2. Because of your problem, do you feel frustrated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F3. Because of your problem, do you restrict your travel for business or recreation?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P4. Does walking down the aisle of a supermarket increase your problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F5. Because of your problem, do you have difficulty getting into or out of bed?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F7. Because of your problem, do you have difficulty reading?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P . Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E9. Because of your problem, are you afraid to leave your home without someone accompanying you?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E10. Because of your problem, have you been embarrassed in front of others?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P11. Do quick movements of your head increase your problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F12. Because of your problem, do you avoid heights?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P 13. Does turning over in bed increase your problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F14. Because of your problem, is it difficult for you to do strenuous house work or yard work?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E15. Because of your problem, are you afraid people may think you are intoxicated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F16. Because of your problem, is it difficult for you to go for a walk by yourself?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P17. Does walking down a sidewalk increase your problem?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E1 . Because of your problem, is it difficult for you to concentrate?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F19. Because of your problem, is it difficult for you to walk around your house in the dark?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E20. Because of your problem, are you afraid to stay home alone?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E21. Because of your problem, do you feel handicapped?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E22. Has your problem placed stress on your relationships with members of your family or friends?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E23. Because of your problem, are you depressed?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F24. Does your problem interfere with your job or household responsibilities?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P25. Does bending over increase your problem?

Examiner

OTHER COMMENTS: _____