DIZZINESS HANDICAP INVENTORY

Patient Name _____ Date_____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 byt <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		
☐	☐	☐	P1.	Does looking up increase your problem?
☐	☐	☐	E2.	Because of your problem, do you feel frustrated?
☐	☐	☐	F3.	Because of your problem, do you restrict your travel for business or recreation?
☐	☐	☐	P4.	Does walking down the aisle of a supermarket increase your problem?
☐	☐	☐	F5.	Because of your problem, do you have difficulty getting into or out of bed?
☐	☐	☐	F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?
☐	☐	☐	F7.	Because of your problem, do you have difficulty reading?
☐	☐	☐	P .	Does performing more ambitious activities like sports, dancing. household chores such as sweeping or putting dishes away increase your problem?
☐	☐	☐	E9.	Because of your problem, are you afraid to leave your home without someone accompanying you?
☐	☐	☐	E10.	Because of your problem, have you been embarrassed in front of others?
☐	☐	☐	P11.	Do quick movements of your head increase your problem?
☐	☐	☐	F12.	Because or your problem, do you avoid heights?
☐	☐	☐	P 1 3.	Does turning over in bed increase your problem?
☐	☐	☐	F14.	Because of your problem, is it difficult for you to do strenuous house work or yard work?
☐	☐	☐	E15.	Because of your problem, are you afraid people may think you are intoxicated?
☐	☐	☐	F16.	Because of your problem. is it difficult for you to go for a walk by yourself?
☐	☐	☐	P17.	Does walking down a sidewalk increase your problem?
☐	☐	☐	E1 .	Because of your problem, is it difficult for you to concentrate?
☐	☐	☐	F19.	Because of your problem, is it difficult for you to walk around your house in the dark?
☐	☐	☐	E20.	Because o(your problem, are you afraid to stay home alone?
☐	☐	☐	E21.	Because of your problem, do you feel handicapped?
☐	☐	☐	E22.	Has your problem placed stress on your relationships with members of your family or friends?
☐	☐	☐	E23.	Because of your problem, are you depressed?
☐	☐	☐	F24.	Does your problem interfere with your job or household responsibilities?
☐	☐	☐	P25.	Does bending over increase your problem?

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Examiner

OTHER COMMENTS:_____