Name_____

Date_____

Reason for Visit_____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

P1. Does looking up increase your problem?	Yes	Sometimes	No
E2. Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
F7. Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
E9. Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
E10. Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
P11. Do quick movements of your head increase your problem?	Yes	Sometimes	No
F12. Because of your problem, do you avoid heights?	Yes	Sometimes	No
P13. Does turning over in bed increase your problem?	Yes	Sometimes	No
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E15. Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P17. Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E18. Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F19. Because of your problem, is it difficult for you to go for a walk around your house in the dark?	Yes	Sometimes	No
E20. Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E21. Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E22. Has your problem placed stress on your relationship with members of your family or friends?	Yes	Sometimes	No
E23. Because of your problem, are you depressed?	Yes	Sometimes	No
F24. Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
P25. Does bending over increase your problem?	Yes	Sometimes	No

Part II

Instructions: Put a check in the box that best describes you.

- □ **Negligible symptoms (0)**
- □ **Bothersome symptoms (1)**
- □ **Performs usual work duties but symptoms interfere with outside activities (2)**
- □ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- □ **Currently on medical leave or had to change jobs because of symptoms (4)**
- □ **Unable to work for over one year or established permanent disability with compensation payments (5)**