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		
_____	_____	_____	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?
_____	_____	_____	P8.	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 of your problem, do you avoid heights? .
_____	_____	_____	P13.	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?
_____	_____	_____	E18.	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 of 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?

_____
Examiner

OTHER COMMENTS:_____