

Dizziness Handicap Inventory

Date: _____

Patient: _____ Date of Birth: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

ITEM	QUESTION	P	E	F	Y	N	S
1	Does looking up increase your problem?	P					
2	Because of your problem, do you feel frustrated?	E					
3	Because of your problem, do you restrict your travel for business or recreation?	F					
4	Does walking down the aisle of a supermarket increase your problem?	P					
5	Because of your problem, do you have difficulty getting into or out of bed?	F					
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F					
7	Because of your problem, do you have difficulty reading?	F					
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P					
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E					
10	Because of your problem, are you embarrassed in front of others?	E					
11	Do quick movements of your head increase your problem?	P					
12	Because of your problem, do you avoid heights?	F					
13	Does turning over in bed increase your problem?	P					
14	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	F					
15	Because of your problem, are you afraid people may think you are intoxicated?	E					
16	Because of your problem, is it difficult for you to walk by yourself?	F					
17	Does walking down a sidewalk increase your problem?	P					
18	Because of your problem, is it difficult for you to concentrate?	E					
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F					
20	Because of your problem, are you afraid to stay at home alone?	E					
21	Because of your problem, do you feel handicapped?	E					
22	Has your problem placed stress on your relationships with members of your family or friends?	E					
23	Because of your problem, are you depressed?	E					
24	Does your problem interfere with your job or household responsibilities?	F					
25	Does bending over increase your problem?	P					
					x4	x0	x2
=							
TOTAL							

P _____ E _____ F _____

□ 100-70 = severe perception of having a handicap, □ 69-40 = moderate perception of handicap, □ 39-0 = low perception of handicap.