

Patient

MRN

Date



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### 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.

- |   |     |           |    |
|---|-----|-----------|----|
| 1. Does looking up increase your problem?   | Yes | Sometimes | No |
| 2. Because of your problem, do you feel frustrated?   | Yes | Sometimes | No |
| 3. Because of your problem, do you restrict your travel for business or recreation?   | Yes | Sometimes | No |
| 4. Does walking down the aisle of a supermarket increase your problem?  | Yes | Sometimes | No |
| 5. Because of your problem, do you have difficulty getting into or out of bed?  | Yes | Sometimes | No |
| 6. 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 |
| 7. Because of your problem, do you have difficulty reading?   | Yes | Sometimes | No |
| 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?        | Yes | Sometimes | No |
| 9. Because of your problem, are you afraid to leave home without having someone with you?   | Yes | Sometimes | No |
| 10. Because of your problem, have you been embarrassed in front of others?  | Yes | Sometimes | No |
| 11. Do quick movements of your head increase your problem?  | Yes | Sometimes | No |
| 12. Because of your problem, do you avoid heights?  | Yes | Sometimes | No |
| 13. Does turning over in bed increase your problem?   | Yes | Sometimes | No |
| 14. Because of your problem, is it difficult for you to do strenuous housework or yard work?  | Yes | Sometimes | No |
| 15. Because of your problem, are you afraid people may think you are intoxicated?   | Yes | Sometimes | No |
| 16. Because of your problem, is it difficult for you to go for a walk by yourself?  | Yes | Sometimes | No |
| 17. Does walking down a sidewalk increase your problem?   | Yes | Sometimes | No |
| 18. Because of your problem, is it difficult for you to concentrate?  | Yes | Sometimes | No |
| 19. Because of your problem, is it difficult for you to go for a walk around your house in the dark?  | Yes | Sometimes | No |
| 20. Because of your problem, are you afraid to stay home alone?   | Yes | Sometimes | No |
| 21. Because of your problem, do you feel handicapped?   | Yes | Sometimes | No |
| 22. Has your problem placed stress on your relationship with members of your family or friends?   | Yes | Sometimes | No |
| 23. Because of your problem, are you depressed?   | Yes | Sometimes | No |
| 24. Does your problem interfere with your job or household responsibilities?  | Yes | Sometimes | No |
| 25. Does bending over increase your problem?  | Yes | Sometimes | No |