



## Dizziness Handicap Inventory

Name: \_\_\_\_\_

Date: \_\_\_\_\_

INSTRUCTIONS: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness and unsteadiness. Please indicate answer by circling "yes", or "no", or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problems only.

- |                                                                                                                                                           |     |    |           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|-----------|
| 1. Does looking up increase your problem?                                                                                                                 | Yes | No | Sometimes |
| 2. Because of your problem, do you feel frustrated?                                                                                                       | Yes | No | Sometimes |
| 3. Because of your problem, do you restrict your travel for business or recreation?                                                                       | Yes | No | Sometimes |
| 4. Does walking down the aisle of a supermarket increase your problem?                                                                                    | Yes | No | Sometimes |
| 5. Because of your problem, do you have difficulty getting into or out of bed?                                                                            | Yes | No | Sometimes |
| 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 | No | Sometimes |
| 7. Because of your problem, do you have difficulty reading?                                                                                               | Yes | No | Sometimes |
| 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?        | Yes | No | Sometimes |
| 9. Because of your problem, are you afraid to leave home without having someone with you?                                                                 | Yes | No | Sometimes |
| 10. Because of your problem, have you been embarrassed in front of others?                                                                                | Yes | No | Sometimes |
| 11. Do quick movements of your head increase your problem?                                                                                                | Yes | No | Sometimes |
| 12. Because of your problem, do you avoid heights?                                                                                                        | Yes | No | Sometimes |
| 13. Does turning over in bed increase your problem?                                                                                                       | Yes | No | Sometimes |
| 14. Because of your problem, is it difficult for you to do strenuous housework or yard work?                                                              | Yes | No | Sometimes |
| 15. Because of your problem, are you afraid people may think you are intoxicated?                                                                         | Yes | No | Sometimes |
| 16. Because of your problem, is it difficult for you to go for a walk by yourself?                                                                        | Yes | No | Sometimes |
| 17. Does walking down a sidewalk increase your problem?                                                                                                   | Yes | No | Sometimes |