

Dizziness Handicap Inventory

Patient Name _____ Date _____

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

DHI Score _____