Dizziness Handicap Inventory Questionnaire

Name: ____DOB:_________________ Date:________________________

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 "some" (sometimes affected) to each question. *Answer as it applies to your dizziness or unsteadiness only.*

	Question			
	Does looking up increase your problem?	Yes	Some	No
	Because of your problem, do you feel frustrated?	Yes	Some	No
	Because of you problem, do you restrict your travel for business or recreation?	Yes	Some	No
	Does walking down the aisle of a supermarket increase your problem?	Yes	Some	No
	Because of your problem, do you have difficulty getting into or out of bed?	Yes	Some	No
	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or to parties?	Yes	Some	No
	Because of your problem, do you have difficulty reading?	Yes	Some	No
	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Some	No
	Because of your problem, are you afraid to leave your home without someone accompanying you?	Yes	Some	No
	Because of your problem, have you been embarrassed in front of others?	Yes	Some	No
	Do quick movements of your head increase your problem?	Yes	Some	No
	Because of your problem, do you avoid heights?	Yes	Some	No
	Does turning over in bed increase your problem?	Yes	Some	No
	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Some	No
	Because of your problem, are you afraid people may think you are intoxicated?	Yes	Some	No
	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Some	No
	Does walking down a sidewalk increase your problem?	Yes	Some	No
	Because of your problem, is it difficult for you to concentrate?	Yes	Some	No
	Because of your problem, is it difficult for you to walk around your house in the dark?	Yes	Some	No
	Because of your problem, are you afraid to stay home alone?	Yes	Some	No
	Because of your problem, do you feel handicapped?	Yes	Some	No
	Has your problem placed stress on you relationships with members of your family or friends?	Yes	Some	No
	Because of your problem, are you depressed?	Yes	Some	No
	Does your problem interfere with your job or household responsibilities?	Yes	Some	No
	Does bending over increase your problem?	Yes	Some	No