PATIENT NAME: ___________________________________ DATE:___________________________

DIZZINESS HANDICAP INVENTORY

Please rate your pain level with activity:

NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

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

Question			
P1. Does looking up increase your problem?	☐Yes	☐No	☐Sometimes
E2. Because of your problem, do you feel frustrated?	☐Yes	☐No	☐Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	☐Yes	☐No	☐Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	☐Yes	☐No	☐Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	☐Yes	☐No	☐Sometimes
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parities?	☐Yes	☐No	☐Sometimes
F7. Because of your problem, do you have difficulty reading?	☐Yes	☐No	☐Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	☐Yes	☐No	☐Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	☐Yes	☐No	☐Sometimes
E.10 Because of your problem, have you been embarrassed in front of others?	☐Yes	☐No	☐Sometimes
P11. Do quick movements of your head increase your problem?	☐Yes	☐No	☐Sometimes
F12. Because of your problem, do you avoid heights?	☐Yes	☐No	☐Sometimes
P13. Does turning over in bed increase your problem?	☐Yes	☐No	☐Sometimes
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐Yes	☐No	☐Sometimes
E15. Because of your problem, are you afraid people might think you are intoxicated?	☐Yes	☐No	☐Sometimes
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	☐Yes	☐No	☐Sometimes
P17. Does walking down a sidewalk increase your problem?	☐Yes	☐No	☐Sometimes
E18. Because of your problem, is it difficult for you to concentrate?	☐Yes	☐No	☐Sometimes
F19. Because of your problem, is it difficult for you to walk around the house in the dark?	☐Yes	☐No	☐Sometimes
E20. Because of your problem, are you afraid to stay home alone?	☐Yes	☐No	☐Sometimes
E21. Because of your problem, do you feel handicapped?	☐Yes	☐No	☐Sometimes
E22. Has your problem placed stress on your relationships with members of your family or your friends?	☐Yes	☐No	☐Sometimes
E23. Because of your problem, are you depressed?	☐Yes	☐No	☐Sometimes
F24. Does your problem interfere with your job or household responsibilities?	☐Yes	☐No	☐Sometimes
P25. Does bending over increase your problem?	☐Yes	☐No	☐Sometimes

Put a check in the box that best describes you:

☐ Negligible symptoms (0)
☐ Bothersome symptoms (1)
☐ Performs usual wok duties but symptoms interfere with outside activities (2)
☐ Symptoms disrupt performance of both usual work duties and outside activities (3)
☐ Currently on medical leave or had to change jobs because of symptoms (4)
☐ Unable to work for over one year or established permanent disability with compensation payments (5)

Dizziness Handicap Inventory © 1990, American Medical Association